

Consent to Obtain External Pharmacy History

Why are we asking for this?

An accurate prescription history reduces medication errors and enhances your safety.

When you authorize **Srirengam Muralidhasan, M.D., LLC** access your external prescription history, you provide our staff with information about the medications you are already taking. This information will help **Srirengam Muralidhasan, M.D., LLC** to minimize adverse drug events.

Drug interactions are examples of an adverse drug event. When you sign this consent, you are agreeing that **Srirengam Muralidhasan, M.D., LLC** may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

The Consent Statement

I understand that the prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be accessed by my provider and **Srirengam Muralidhasan, M.D., LLC**. This may include prescriptions dating back several years.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

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Print Name

Date of Birth

Patient or Guardian

Signature Date