FAMILY HEALTH NP, PLLC

CONSENT TO E PRESCRIBE

Patient Name: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I understand that:

1. ON CARE FAMILY HEALTH NP, PLLC uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to ON CARE FAMILY HEALTH NP, PLLC.

2. This authorization may include disclosure of prescriptions information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc to ON CARE FAMILY HEALTH NP, PLLC.

3. I have the right to revoke this authorization at any time by writing to ON CARE FAMILY HEALTH NP, PLLC. I understand that I may revoke authorization except to the extent that action has already been taken based on authorization.

4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.

THIS AUTHORIZATION DOES NOT AUTHORIZE ON CARE FAMILY HEALTH NP, PLLC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

_____ _____

Printed Name of Patient Patient's Date of Birth

_____ _____

Patient Signature Today's Date