ELECTRONIC PRESCRIPTION FORM

Patient Name: _____ **Date of Birth:** _____

I, _____, whose signature appears below, authorize Lung Care & to view the external prescription history via the RxHub service for the patient listed below.

Please initial. By initialing, you are agreeing to the respective terms and conditions set below and are fully agreeing to the terms above.

_____ I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff here, and may include prescriptions back in time for several years.

_____ (Patient Name)

My signature certifies that I have read and understand the above and that I authorize the access.

Signature of Patient _____ Date: _____