ELECTRA
HOSPITAL DISTRICT

PRESCRIPTION HISTORY CONSENT

I authorize Electra Hospital District (EHD) and its providers and staff to view my prescription history via the electronic medical records system, SureScripts, and/or any other system necessary to verify medications prescribed to me.

I understand that my prescription history will include information from other unaffiliated providers, insurance companies, and pharmacy benefit managers.

I understand that this Prescription History Consent will remain in effect as long as I receive services from Electra Hospital District, unless revoked by me in writing.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THIS PRESCRIPTION HISTORY CONSENT.

Print Patient Name	Date of Birth
Patient / Legally Authorized Representative Signature	Date
Authorized Representative Name	Relation to Patient