

ePrescribing Consent

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

The Retina Care Center has implemented **ePrescribing** in each of our offices.

- ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.
- ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.
- ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

The benefit to you:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster, easier way to get your prescription filled (note: refill requests should be made directly to your pharmacy)

PREFERRED PHARMACY INFORMATION:

Name of Pharmacy: _____

Address: _____ Zipcode: _____

Phone: _____

Patient Consent

I agree that The Retina Care Center may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

This consent is valid for two years. Please notify us if your pharmacy information should change.

Patient Signature _____ Date _____