BANNER ARIZONA MEDICAL CLINIC
PRESCRIPTION MEDICATION HISTORY CONSENT FORM

Banner Arizona Medical Clinic providers utilize electronic E-prescribing to send and receive our patient prescriptions to pharmacies. E-prescribing will generate accurate, error-free, understandable and legible prescriptions from our electronic medical record system delivered directly to participating pharmacies. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medication Modernization Act (MMA) of 2003 listed standards that must be included:

*Formulary and benefit transaction - Gives the prescriber information about which drugs are covered by the drug benefit plan.

*Medication history transactions - Provides the physician with information about medications the patient is already taking to minimize adverse drug events.

* Fill status notification - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up not picked up, or partially filled.

ACCEPT:

I hereby authorize Banner Arizona Medical Clinic to request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. I understand that I may revoke this authorization at any time by completing another copy of this consent form. I also understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release Banner Arizona Medical Clinic, it's employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the information to the extent indicated and authorized herein.

This consent will expire upon notification of my revocation of this authorization or notification that I will permanently be discontinuing care at Banner Arizona Medical Clinic.

_______________________________________ _______________

Patient/Responsible Party Signature Date

DECLINE:

I hereby decline consent for Banner Arizona Medical Clinic to use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. I understand that Banner Arizona Medical Clinic may not condition my treatment, payment, enrollment or elegibility for benefits because I have declined this authorization.

_______________________________________ _______________

Patient/Responsible Party Signature Date

REVOKE AUTHORIZATION:

I hereby revoke authorization for Banner Arizona Medical Clinic to use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

_______________________________________ _______________

Patient/Responsible Party Signature Date