ENT AND ALLERGY SPECIALISTS

Authorization to View Prescription History From External Sources

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Patient's or Authorized Person's Consent:

You have my permission to view prescription history from external sources for the following:

PATIENT NAME _____

DOB _____

Relationship to the Patient (please check)

❑ SELF

❑ PARENT

❑ OTHER _____

Signature _____

(Must be 18 years of age or parent/legal guardian)

Signature of Parent or Legal Guardian _____