Orthopedic Specialists & Sports Medicine

An OrthoAlliance Partner Practice

Patient Name: _____

Date of Birth: _____

Sure Scripts Prescription History Consent

I, _____, give my consent and authorization to Sure Scripts to disclose any and all medication prescription information maintained by Sure Scripts to my current OrthoAlliance provider and its affiliated Practices and their providers involved in my healthcare. I understand that this prescription information may include prescriptions that were prescribed to me by my providers who are not OrthoAlliance providers. I understand that the prescription information may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health, or substance abuse and I authorize its disclosure, if any such information is contained in Sure Scripts' records. This disclosure by Sure Scripts is for the purpose of assisting with my care. This authorization is valid for one year from the date signed. I understand I may revoke this authorization at any time by providing written notice to OrthoAlliance and that my revocation will not apply to information that has already been released.

Information used or disclosed as per this authorization may be re-disclosed by the provider receiving the information and may no longer be protected by federal or state law**.** Signing this authorization is voluntary and I can refuse to sign this authorization. My right to health care treatment is not conditioned on this authorization. I understand that I may request a copy of this authorization.

Signature: _____ **Date**: _____

If person signing form is not the patient, please print your name and list relationship to patient:

Name _____ ***Relationship*** _____