



Consent to Obtain Prescription History

This consent form authorizes Texas Center for Digestive Health to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form you agree that Texas Center for Digestive Health can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Texas Center for Digestive Health to request, view, and use my external prescription history for treatment purposes.

Patient Name (Printed): _____

Patient Date of Birth: _____

Patient Signature: _____

Date of Signing Consent Form: _____