John M. Rowley, M.D.
Palo Verde Plastic Surgery

Palo Verde Plastic Surgery
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Authorization for Release and Disclosure of Protected Health Information

PLEASE FILL OUT COMPLETLEY AND PRINT CLEARLY

Consent related to the Privacy Notice:
I hereby give my consent to John M Rowley, MD and/or "this practice" to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this practice.
I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing.

Please allow those listed below access to my Protected Health Information (PHI):

Name: _____ Relationship:_____

Name: _____ Relationship:_____

PATIENT/RESPONISBLE PARTY PRINTED: _____

PATIENT/RESPONISBLE PARTY SIGNATURE: _____

DATE: _____

Consent to Obtain External Prescription History

The purpose of this consent is for permission to obtain your medication history. Patient medication history is a list of prescription medicines that our providers or other providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribution to the collection of this history. The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record.

Medication history is very important in helping healthcare providers treat your symptoms and/or illnesses properly and in avoiding potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history may not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements and/or herbal remedies that patients take on their own may not be included. By signing this consent form, you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan.

I certify that I have read and fully understand the above Notice of Privacy Practices and Consent to obtain External Prescription history. That by signing below, I am consenting fully and voluntarily to allow Palo Verde Plastic Surgery to obtain my medication history and acknowledge that I have read and fully understand Notice of Privacy Practices.

PATIENT/RESPONISBLE PARTY PRINTED: _____

PATIENT/RESPONISBLE PARTY SIGNATURE: _____

DATE: _____