OBGYN of Jacksonville
TopLine MD Alliance

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Patient Consent for E-Prescribing (Electronic Prescribing)

Date: _____

I have been made aware and understand that the medical practice and office may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy.

I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers.

I give my consent to my providers to see this protected health information.

Patient printed name:	Date:
Patient signature:	Interpreter, if utilized:
Parent's Printed Name (If patient is a minor): Parent's Relationship to Patient:	
Parent's Signature (If patient is a minor):	