# ***Authorization for External Prescription History***

Our office is now using E-scribe to electronically send your prescriptions to your requested pharmacy. Signing the form below authorizes our office to verify medications and check for potential interactions.

**Patient name:** ________________________________________

(*Please print*)

**Date of Birth:** ____________

**If name listed above is not yours:**

I _____________________________________ ____________________

(*Printed Name*) (*Relationship*)

give Independence Park Medical Services permission to verify prescription history.

**Signature:** ______________________________ **Date:** ________________