CARDIOLOGY
CONSULTANTS, PC

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MEDICATION HISTORY CONSENT AUTHORIZATION

By signing below, I hereby authorize Cardiology Consultants, P.C. to obtain Medication History from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of continued treatment.

_____
Date of Authorization

_____ _____
Print Name **Date of Birth**

_____
(Signature) Patient / Legal Representative or Parent / Legal Guardian

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Cardiology Consultants, P.C. may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

PHARMACY: _____

LOCATION: _____