****PATIENT SECURE MESSAGING PORTAL****

Do you want future access to your records YES NO

Patient's Name: _____ Date of Birth: _____
Legal Guardian: _____ Date of Birth: _____

ONLY THE PATIENT OR LEGAL GUARDIAN (Documents on file) can access this portal

EMAIL ADDRESS: _____ Date:_____

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

I understand that my medication history may be obtained utilizing electronic information exchange and that this protected health information may provide valuable information for my healthcare provider.
I hereby authorize The Hubbell Eye Clinic to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

Pharmacy Name: **_____ Location**:_____

Patient/guardian signature: _____ Date:_____

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