Mill City Medical Group

45 Palmer Street

Lowell, MA 01852-1834

978-970-1607

CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY

Please sign only after you have read and understand the following

Patient Name (please print)_________________________________ Date of birth:_______________

I, (please print)____ whose signature appears below, authorize **Mill City Medical Group** and its affiliated providers to view the external prescription history via the Rx Hub service for the patient listed below.

I understand that a prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by the providers and staff of **Mill City Medical Group** and may include past prescriptions from several years ago.

MY SIGNATURE CERTIFIES THAT I HAVE READ, UNDERSTAND AND AUTHORIZE THE ACCESS OF EXTERNAL PRESCRIPTION HISTORY.

_________________________________ __________ ______________________________

Signature of Patient or Guardian **Date** **If guardian, relationship to patient**

_________________________________ ____________________

Witness to Signature **Date**