West Suburban
Women's Health, Ltd.

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PBM CONSENT FORM

Patient Name Printed:_____ Date of Birth:_____

We have implemented a new Electronic Prescribing System that allows us to automatically import your medication history from outside practices and pharmacies. This is to prevent our practice from prescribing anything that may conflict with any existing medications as well as to assist you in providing a list with medication names and dosages. In order to transfer your current and past medication list to our electronic medical record, we must have your consent. Please read the statement below and sign if you agree.

By electronically signing below, I hereby authorize West Suburban Women's Health to obtain my medication history. *

_____ _____
(Signature of patient or authorized representative) (Printed name)

_____ _____
(Name of patient if different from above) (Today's Date)

_____
(If signed above by representative, relationship of signer to patient)