*Houston Female Urology][**PRESCRIPTION HISTORY CONSENT***

I voluntarily consent to provide Houston Female Urology access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Houston Female Urology may use health information exchange systems to electronically transmit, receive and/or access my prescription history. I understand that this Prescription History Consent will be valid and remain in effect as long as I receive services from Houston Female Urology, unless revoked by me in writing.

By signing this consent I also confirm that I have received and understand the Notice of Privacy Practices and how the practice may use and/or disclose protected health information. I understand that Houston Female Urology cannot be responsible for use or re-disclosure of information by third parties.

I certify that I have read this form and/or it has been read to me.

Date: _____

Print Name (Patient): _____

DOB: _____

Signature of Patient/Legally Authorized Representative:

_____

Relationship to Patient (if Patient not signing): _____

For patients requiring translation or verbal reading of this consent, the person reading or translating should document and sign below:

Reader/Translator Signature: _____

Date: _____