



**Consent to Obtain External Prescription History**

I, \_\_\_\_\_, whose signature appears below, authorize First Choice Primary Care’s providers and staff to view my external prescription history in the RxHub service.

I understand my prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers will be viewable by First Choice Primary Care’s providers and staff, and the information may include prescriptions I had filled over the past several years.

MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ AND UNDERSTAND THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date