# Delo Medical Associates

## Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Delo Medical Associates and Its Affiliated Providers to view my external prescription history via the RxHub service.

I understand that 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 going back several years.

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

_____ _____

Patient Date

_____ _____

Witness Date

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