Consent to Obtain External Prescription History

By signing below I give permission, without limitation of exclusion, for Southeast Medical Clinic and it's providers to view my external prescription history via the Surescripts for purposes of my care and treatment.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable and that granting this permission will allow my providers to better coordinate my care and to maximize the effectiveness and safety of my treatment.

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

____________________________________ __________________

Patient Signature Date

____________________________________ __________________

Print Name DOB

Southeast Medical Clinic
641 W. Willoughby Ave Suite 201
Juneau, AK 99801
(907) 586-8100