Matthew A. Berger, MD, PC
340 Montage Mountain Road ●Moosic, PA 18507
Phone (570) 346-3686 ● Fax (570) 207-0615

AUTHORIZATION
TO RETRIEVE MEDICATION HISTORY

Name ______________________ **Date** ____________ **Patient Account #** ____________
(Please Print) (Office Use Only)

PATIENT AUTHORIZATION

I hereby give permission to Matthew A. Berger, MD, PC or his designee to retrieve and use my medication history for SureScripts.

Patient Signature* ______________________ **Date** ____________

Legal Guardian Name** ______________________

Legal Guardian Signature** ______________________ **Date** ____________

---

*If patient is **14 or older**, patient must sign all paperwork and add legal guardians to their HIPAA.

If patient is **13 or under, a legal guardian must sign all paperwork.

If you have any questions, please ask our staff.