Acknowledgement of Electronic Submission of Prescriptions, Consent to Retrieve Medication History, Consent for Referrals and Consent for Electronic Document Transfer through Community Exchange

I, ____, authorize the Sleep Disorders Center of Alabama to submit my prescriptions electronically to my preferred pharmacy(s).

I, ____, authorize the office of the Sleep Disorders Center of Alabama to retrieve my prescription history via the SureScripts clearinghouse.

ePrecribing is a physician's ability to electronically send an accurate and understandable prescription directly to a pharmacy from the point of care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- Formulary and benefit transactions — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Sleep Disorders Center of Alabama can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Sleep Disorders Center of Alabama to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

I, ____, authorize the office of the Sleep Disorders Center of Alabama to make referrals on my behalf and share relevant clinical and demographic information.

I, ____, authorize the office of the Sleep Disorders Center of Alabama to transfer medical documents to/from my other physicians through Community Exchange in order to provide the best care.

Please list your current Pharmacy information below.

Name of Pharmacy: ____

Telephone Number: ____

Address: ____

______________________________ ______________

Patient Signature Date