Behavioral Health of Cleveland
A SkyRidge Health Partner

Medication History Notice: Acknowledgement

Patient Name: _____

Date of Birth: _____

I, _____ understand that my physician may need access to my medication history and may work in conjunction with my pharmacy in order to provide accurate medical treatment.

_____

Patient Signature Date

_____

Personal Representative Signature Relationship to Patient

For Office Use Only:

- Patient refused to sign
- Patient unable to sign due to communication/language barrier
- Patient unable to sign due to emergency situation
- Other(please explain)

_____

_____

_____

_____

Office Representative Signature Date

Behavioral Health of Ooltewah

A SkyRidge Health Partner

Medication History Notice: Acknowledgement

Patient Name: _____

Date of Birth: _____

I, _____ understand that my physician may need access to my medication history and may work in conjunction with my pharmacy in order to provide accurate medical treatment.

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Patient Signature Date

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Personal Representative Signature Relationship to Patient

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Office Representative Signature Date