

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

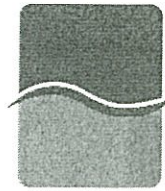
Relationship to Patient

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

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