Northeast Surgical Group, P.C.

**CONSENT TO RELEASE FOR TREATMENT PURPOSES**

_____ _____

**Patient Legal Name, PRINTED** **Patient Date of Birth**

The purpose of this form is to obtain your consent to Sure Scripts to disclose to Northeast Surgical Group, P.C. your prescription medication history and other protected health information that have special privacy protections under federal and state law as listed below:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

I understand the above-listed information will only be shared to the extent required in order for Northeast Surgical Group, P.C. to provide me with treatment, coordinate care and/or receive payment for their care.

By signing this form, I understand:

- I am giving consent to share my prescription medication history and the other PHI listed above.
- I understand that Sure Script's disclosure of my PHI to Northeast Surgical Group, P.C. is solely to for the purposes of diagnoses, treatment, management and payment for services to me.
- Sure Scripts may share my health information Northeast Surgical group, P.C. electronically.
- My consent is voluntary and I understand that I can withdraw or revoke this consent at any time. I understand that the only exception to my right to revoke is if Sure Scripts has already acted in reliance upon the consent.
- This consent is perpetual and will continue unless and until it is revoked by me.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Signature: _____ Date _____

Printed patient name: _____

Relationship to patient: ☐ SELF/PATIENT ☐ PARENT OF MINOR CHILD ☐ LEGAL GUARDIAN ☐ Power of Attorney