ROCKY MOUNTAIN™
CANCER CENTERS

Patient Name: _____

MRN: _____

PRESCRIPTION HISTORY CONSENT

I voluntarily consent to provide Rocky Mountain Cancer Centers access to and use of my prescription medication history from other health care providers or third party pharmacy benefit payers for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Rocky Mountain Cancer Centers may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from Rocky Mountain Cancer Centers unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

☐ **I certify that I have read this form or it has been read to me.**

Date: _____

_____ _____

Patient Name or Personal Representative (Please print) **Patient's Date of Birth**

_____ _____ _____

Signature of Patient or Personal Representative **Relationship to Patient (If patient not signing)** **Date**

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

_____ _____

Reader/Translator Signature **Date of Birth**

Rocky Mountain Cancer Centers complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 303-930-7880 (TTY: 711).