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CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I, _____, whose signature appears below authorize for Flagler Medical Associates and its affiliated providers to view my external prescription history via the RXHUB service.

I understand that prescription history from multiple other unaffiliated medical providers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

Patient Name

Date

Witness

Date