capitalhealth
CENTER FOR
COMPREHENSIVE BREAST CARE

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MEDICATION HISTORY AND BENEFITS CONSENT

I give permission for the Capital Health and the Center for Comprehensive Breast Care to obtain my current medications and medication history from the SureScripts Pharmacy Clearinghouse.

I understand that this information will be stored in my Electronic Health Record and may be used in the normal course of my treatment at the Center for Comprehensive Breast Care.

Signature: _____

Today's Date:_____