



**Human Services**

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**Public Health Center**  
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## Consent to Obtain Patient Medication History

Patient Name \_\_\_\_\_

Patient ID# \_\_\_\_\_ Date of Birth \_\_\_\_\_

I understand that as part of my/the patient's health care, WCHS may obtain my/the patient's medication history by utilizing electronic information exchange through Surescripts Rx Hub. This medication history may help with treatment and avoid potentially dangerous drug interactions. I understand that the medication history obtained becomes part of my/the patient's electronic medical record.

I understand that the Surescripts RxHub may contain information about my/the patient's prescriptions that have been filled at any pharmacy at any location and are covered by any health insurance plan. This includes but is not limited to prescription medicines to treat AIDS/HIV, medicines used to treat mental health conditions (such as depression, anxiety, or bi-polar disorder), or medicines used to treat a substance use disorder (such as alcohol or drug abuse).

I understand that the patient medication history obtained through Surescripts Rx Hub may not be complete. It may not include information from a pharmacy that does not make drug histories available, or drugs purchased without using insurance. It also may not include over the counter medicines, vitamins, supplements, or herbal remedies. I understand that I/the patient should still discuss my/the patient's full medication history with the care provider.

Wake County Human Services Notification of Privacy Practices contains further information about how my/the patient's health information, which includes this medication history, may be used. The Notification of Privacy Practices is available upon request.

\_\_\_\_\_ I hereby give my consent for Wake County Human Services to obtain the medication history of the above named patient from the Surescripts RxHub, my/the patient's pharmacy, health plans, and other healthcare providers as required or advisable to disclose, process, retrieve, transmit, and/or view as necessary for my/the patient's care and treatment.

\_\_\_\_\_ I DO NOT give my consent for Wake County Human Services to obtain the medication history of the above named patient from the Surescripts RxHub, the patient's pharmacy, health plans, and other healthcare providers.

\_\_\_\_\_  
Signature of Patient / Authorized Representative

\_\_\_\_\_  
Date

- I am \_\_\_ the patient  
\_\_\_ the parent of the patient, who is under 18 years of age  
\_\_\_ an authorized court-appointed representative of the patient