

# CENTRAL OZARKS MEDICAL CENTER



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**THE LAKE**  
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## Consent to Obtain External Prescription History

I, \_\_\_\_\_, authorize Central Ozarks Medical Center to view my prescription history.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff at Central Ozarks Medical Center, and may contain prescriptions dating back several years.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE ACCESS.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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I **do not** consent for Central Ozarks Medical Center or its Affiliated Providers to access my external prescription history.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

