Anderson Hills PEDIATRICS

7400 Jager Court
Cincinnati, Ohio 45230-4380
(513) 232-8100 Fax (513) 624-3191

1126 Ohio Pike
Amelia, Ohio 45102-9306
(513) 232-8100 Fax (513) 943-6154

E-PRESCRIBING CONSENT FORM

E-prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Anderson Hills Pediatrics, Inc. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Anderson Hills Pediatrics, Inc. to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization.

IF PATIENT IS 18 YEARS OR OLDER THEY MUST SIGN THIS CONSENT FORM. A PARENT/GRANDPARENT MAY NOT SIGN FOR THEM.

☐ **Accept** ☐ **Decline**

Print Patient(s) Name_____ **DOB** _____ **Sibs Name** _____ **DOB** _____

Sibs Name_____ **DOB** _____ **Sibs Name** _____ **DOB** _____

Sibs Name _____ **DOB** _____ **Sibs Name** _____ **DOB** _____

Signature of Patient/Guardian or Self_____

Relationship to Patient(s)_____ **Today's Date**_____

****** If only one child or signing for self just ignore other lines. If more than one child, you may fill out one sheet with name and DOB for each child.**