VALLEY INTENSIVISTS, PULMONOLOGISTS AND SLEEP SPECIALISTS
1200 E. Savannah Ave. Suite 12
McAllen, TX 78503
Tel: (956) 688-6300 Fax: (956) 688-6303

MEDICATION HISTORY CONSENT

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

CONSENT

I authorize Valley Intensivists, Pulmonologists and Sleep Specialists (VIPS) to obtain my medication history from external sources, including but not limited to:

- Insurance companies
- Pharmacy benefit managers (PBMs)
- Pharmacies and pharmacy databases

This medication history may include prescriptions filled within the past 12 months and will be used for purposes of treatment, medication reconciliation, and improving accuracy and safety of my medical care.

PATIENT RIGHTS

- I understand that this authorization is voluntary and will not affect my ability to receive treatment.
- I understand that I may revoke this authorization at any time by providing written notice to the office.
- I understand that information obtained may be incorporated into my medical record and used for treatment, payment, and healthcare operations as permitted under HIPAA.

Patient / Legal Representative Name: _____

Signature: _____ Date: _____