Dear Patient,

We are using an Electronic Health Record computer system. We have the ability to send and receive electronic information from pharmacies regarding your current and past prescriptions.

Please sign below allowing us to obtain your information.

I authorize Central Jersey Internal Medicine Associates to obtain all of my medication history, as is medically necessary, in any format, to provide my medical care.

Patient Name_____

Signature_____

Date_____

Pharmacy Name_____

Pharmacy Address_____

Pharmacy Phone Number_____