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Prescription Authorization

I authorize Memorial Hospital of Union County, d/b/a Marysville Orthopedics to access my prescription information/history electronically for use in providing my health care.

Patient/Legal Guardian Signature

Date

Preferred Pharmacy:

Name

Location

Phone

HIPAA REQUEST: (Please mark below)

Call patient at home Phone: _____

Call patient at work Phone: _____

Permission to leave message/medical information on answering machine or voicemail.

Permission to leave message/medical information or results with the following family members:

o Name: _____ Relation: _____ Phone: _____

o Name: _____ Relation: _____ Phone: _____

Emergency Contact:

o Name: _____ Relation: _____ Phone: _____

Patient/Legal Guardian Signature

Date