SARAH B KLINE MD
13601 BRUCE B DOWNS BLVD
STE #211
TAMPA, FL 33613

Pharmacy:______________________________
Address:__________________________________
____
Phone #:________________________________

Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy.

I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers.

I give my consent to my providers to see this protected health information.

____ Date__________________

Parent, Patient's Signature or Authorized Representative

____

Relation to Patient

____

Witness Signature

Print Patient Name

_____________________________________ Act #______________________