ALPHA MED
PHYSICIANS GROUP, LLC

Pharmacy Consent Form

Patient Name: _____ Date of Birth: _____

Account Number: _____

Alpha Med Physicians Group, LLC (AMPG) is enrolled in an electronic prescribing program. This program is meant to help our providers understand what medications our patients are currently using in order to provide the best possible treatment.

By signing this consent form you are agreeing that Alpha Med Physicians Group, LLC (AMPG) may 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 Alpha Med Physicians Group, LLC (AMPG) to enroll me in the ePrescribe program.

_____ _____

Signature of Patient or Representative Date

Pharmacy Name: _____

Address (or cross streets and town): _____

Phone Number: _____