FOXHALL MEDICINE, P.L.L.C.

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AUTHORIZATION FOR RELEASE OF MEDICATION HISTORY

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I, or my authorized representative, consent to allow Foxhall Medicine to download a list of medications purchased through my insurance in the last 12 months, as set forth on this form.

In accordance the DC Law and the Privacy Rule of the Health Insurance Portability and Accountability act of 1996 (HIPAA), I understand that:

1. Foxhall Medicine uses SureScripts, Inc. a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized by Foxhall Medicine.

2. This Authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Foxhall Medicine.

3. I have the right to revoke this authorization at any time by notifying Foxhall Medicine. I understand that I may revoke the authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan. or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

This authorization does not authorize Foxhall Medicine to discuss my health information or medical care with anyone other than those permitted under applicable law.

Signature of patient or representative: _____ Date: _____