Medication History Authorization

I, the undersigned patient (or parent/guardian of the patient if applicable), hereby authorize Mile High Psychiatry, LLC, to collect and review my medication history. I understand that the adoption of an electronic medical record system by Mile High Psychiatry is intended to improve the quality of healthcare services and enhance patient safety.

A medication history is a compilation of prescription medicines that have been recently prescribed for me by Mile High Psychiatry or other healthcare providers. This information is obtained from various sources, including my pharmacy and health insurer.

I acknowledge that having an accurate medication history is crucial to ensure proper and safe medical treatment, as it helps in avoiding potentially dangerous drug interactions. By signing this consent form, I grant Mile High Psychiatry permission to collect and request my pharmacy and health plan to disclose information about my prescriptions, including prescription medicines used to treat mental health conditions such as depression, as well as medicines for other medical conditions, including those related to AIDS/HIV.

I understand that this medication history will become a part of my medical record at Mile High Psychiatry.

It is important to note that while the medication history is a valuable guide, it may not be entirely accurate. Some pharmacies may not provide drug history to Mile High Psychiatry, and certain medications that I purchased without using my health insurance may not be included in the drug history from my health plan. Additionally, over-the-counter medicines, supplements, or herbal remedies might not be captured in the medication history. Therefore, I recognize the importance of discussing all medications and supplements I am taking during my appointments with Mile High Psychiatry and pointing out any errors in my medication history.

I also give my explicit permission to Mile High Psychiatry to obtain my medication history from my pharmacy, health plans, and other healthcare providers for the purpose of ensuring comprehensive and well-informed healthcare services.

Client Name (Printed): _____

Client Signature: _____ Date:_____

Parent/Guardian Signature *(If applicable)*: _____

Date:_____