Camai
Community Health Center

CONSENT FOR PATIENT RECORD SHARING AND MEDICATION HISTORY AUTHORIZATION

Patient Name: _____

Patient Date of Birth: _____

Consent to Share Medical Records
I consent to allow Camai to share and receive my medical records with providers at connected care locations.

_____ Patient/Guardian Initials

Consent to Access Medication History
I consent to allow Camai to download my medication history automatically from pharmacy benefit managers.

_____ Patient/Guardian Initials

I have read the statements above. I understand my rights as a patient and financial responsibility to Camai Community Health Center. If I have additional questions, I will speak to a staff member before my appointment.

Patient Signature: _____

Date: _____

Printed Parent/Guardian Name:

_____

Parent/Guardian Signature:

_____

(if patient is under the age of 18 a parent/guardian signature is required)