Consent to E-Prescribing

E-Prescribing is defined as a physician's ability to electronically send error free, accurate, and understandable prescriptions directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:
Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.
Medication history transactions – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Empower Psychiatry & Sleep LLC, can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all the above, I hereby provide informed consent to Empower Psychiatry & Sleep LLC to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

I give consent to Empower Psychiatry & Sleep LLC., including its medical staff members and employees involved in my care, to access, use and disclose my protected health information for my treatment, payment for my treatment and for health care operations consistent with the federal HIPAA privacy regulation. I consent to the disclosure of my prescription medical information by any provider, pharmacy, insurer, and prescription benefits manager, specifically including any state or federal health benefits program to Empower Psychiatry & Sleep LLC, for the purpose of my treatment. I am aware that the privacy practices of Empower Psychiatry & Sleep LLC, are described in its Notice of Privacy Practices. This Consent is subject to my revocation at any time except to the extent it has already been acted on.

______________________________	______________
Patient Name (Print)	Patient Date of Birth
______________________________	______________
Signature of Patient or Legal Representative	Date and Time
______________________________	______________
Print Patient Representative Name	Relationship to Patient