

SURESCRIPT CONSENT FORM

I,	, authorize Crouse Medical Practice to electronically	
obtain access to my prescription	on history from participating pharma	cies through the
Surescripts network. This will	l assist Crouse Medical Practice prov	viders with prescribing,
assessing health conditions and	d recommending appropriate treatme	ent.
Patient Signature		DOB
Print Name		Date
	d recommending appropriate treatme	