

***Middle Country Endocrinology, P.C.***

Practice Limited to Endocrinology & Metabolism

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**Middle Country Endocrinology may request and use your prescription medication history from other healthcare providers for treatment purposes. This form gives the practice consent to receive this information. You may decide not to sign this form. You also have the right to receive a copy of this form after you have signed it.**

Yes \_\_\_\_\_

No \_\_\_\_\_

\_\_\_\_\_ Print Patient Name

\_\_\_\_\_ Patient Date of Birth

\_\_\_\_\_ Signature of Patient or Guardian

\_\_\_\_\_ Today's Date

\_\_\_\_\_ Relationship to Patient