JOSM
JONESBORO ORTHOPAEDICS
SPORTS MEDICINE

Authorization to Obtain Medication History

Patient Name (Printed): _____

DOB: _____

SSN: _____

Address: _____

By signing below, I hereby authorize Jonesboro Orthopedic and Sports Medicine to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

_____
Date of Authorization

_____
Patient Signature OR Legal Representative and/or Guardian Signature