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## STANDING CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY

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Date

**PLEASE SIGN ONLY AFTER YOU HAVE READ AND UNDERSTAND ALL OF THE FOLLOWING:**

I, \_\_\_\_\_, whose signature appears below, authorize Putnam Parkway Eyecare and its Affiliated Providers to view the external prescription history via the RxHub service for the patient listed below.

**Please initial below. By initialing, you are agreeing to the respective terms and conditions set below and are fully agreeing to the terms above.**

\_\_\_\_\_ I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions issued back in time for several years.

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

**MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT I AUTHORIZE THE ACCESS TO MY PRESCRIPTION HISTORY.**

\_\_\_\_\_  
Signature of Patient or Guardian      Date      If Guardian, Relationship to Patient

\_\_\_\_\_  
Witness to Patient/Guardian's Signature      Date

Preferred Local Pharmacy

Mail Order Pharmacy