



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

MRN #: \_\_\_\_\_

## Southern Regional AHEC Consents

### Photo Consent

I authorize Southern Regional AHEC (SRAHEC) to take my photograph for inclusion in my electronic medical record retained by The Family Medicine Center. I understand this photograph is for the purposes of accurate patient identification, safeguarding my personal information, and familiarization by the office staff and the physician(s). I understand the photo is only used for SRAHEC purposes. I understand it is the policy of SRAHEC to obtain the photograph by the second visit for new patients and the visit following the visit at which this authorization is first made for established patients. I understand that if I refuse to have my photograph taken as required by the SRAHEC policy, I may be asked to find a new practice to provide medical services to me.

### Prescription/Medication History Consent

I authorize Southern Regional AHEC (SRAHEC) to obtain my prescription/medication history electronically from multiple sources including from physicians outside our practice and multiple pharmacies. I authorize SRAHEC to obtain this prescription/medication history as often as SRAHEC determines the information is needed for my medical care. I understand that access to this information is so important to my care that if I refuse to authorize SRAHEC to obtain my prescription/medication history, I may not be allowed to continue as a patient at SRAHEC or, if a new patient, may not be allowed to enroll as a patient at SRAHEC.

**By signing I have read and agree to both of the above consents detailing the Photo Consent and the Prescription/Medication History Consent.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date