Complete Rural
Medicine
515 2nd Street, Friend, NE 68359
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Sure Scripts Patient Consent Form

I am giving consent for Complete Rural Medicine, LLC to view medication history retrieved from Surescripts for myself, _____.
Printed name

Allowing medication history to be reviewed by Surescripts allows for continuity of my care and also for an updated medication list to be accessible for my medical provider.

Disclaimer: Certain information may not be available or accurate in this report, including items that the patient asked not be disclosed due to patient privacy concerns, over-the-counter medications, low cost prescriptions, prescriptions paid for by the patient or non-participating sources, or errors in insurance claims information. The provider should independently verify medication history with the patient.

I have this patient's consent to view their medication history.

◯ YES

◯ NO

Date: _____

Patient printed name: _____

Patient signature: _____

Date: _____

Witness printed name: _____

Witness signature: _____