fbg FORT BEND astroenterology
Stanley H. Stein, M.D., P.A.

MEDICATION HISTORY CONSENT FORM

Date _____

Patient Name: _____

Date of Birth: _____

Dr Stein requests permission to access your current and past medication history. By giving your consent, Dr Stein will be able to query and view electronically all your current medications and those you have taken in the past.

Please indicate your response below:

_____ Yes, I give my consent

_____ No, I do not consent

This consent is effective _____ (enter today's date) and is in effect until further notice.

_____
Signature

_____
Print your name

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