Pediatric Care Associates
299 Carew St, Suite 210
Springfield, MA 01104
413-732-5580

MEDICATION HISTORY AUTHORITY FORM

Date:

I, _____, hereby request and authorize: Pediatric Care Associates to obtain my medication history list through my insurance company and/or the pharmacy manager program.

This authorization is only for the sole reason of my best medical care, and is valid as long as I am associated with Pediatric Care Associates as a patient.

Patient (or person authorized to sign for patient) **Date**

Witness **Date**