Consent to Obtain External Prescription History

I, ___________________________________, whose signature appears below, authorize Periscope Pediatrics LLC and its affiliated providers to view my child's external prescription history via the ePrescribing service. 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 back in time for several years.

Consent to Release Information to ASIIS

I,_____________________________________ , whose signature appears below,, authorize Periscope Pediatrics LLC, to release about all vaccinations given to me, or to the person for whom I am authorized to consent, to the Arizona State Immunization Information System (ASIIS), other health care providers and schools in order to avoid receiving unnecessary vaccinations and to provide information about what immunizations have been received. I understands that I am not required to agree to the release of this information in order to receive the vaccinations I request.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

____ _________________________

Patient Name DOB:

____

Parent/ Legal Guardian Name

____ _________________________

Parent/ Legal Guardian Signature Date