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Pharmacy-Fill Consent Acknowledgement

I, _____, give Darius J Karimipour MD, PC permission to electronically import my pharmacy-fill history through the Surescripts pharmacy network. This permission will remain in force until I contact Darius J Karimipour MD, PC in writing to remove it. I understand that giving Darius J Karimipour MD, PC access to this information will assist in keeping my medical record accurate.

☐ Accept

☐ Decline

Printed Name

Signature/Date

Witness