

**Acknowledgement of Receipt of the Medication Agreement and Refill Policy**

By signing this acknowledgement, I confirm that I have read, understood, and accepted all of the policies and sections in the Medication Agreement and Refill Policy. I agree to comply with the policies of this agreement and understand that failure to comply with this agreement may result in my dismissal as a patient of Antonio A. Flores, M.D. P.A.

**Please note that medication will not be prescribed without the acceptance of this agreement.**

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Patient Name: (Print) Date:

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Patient Signature: Guardian: (If applicable)

**Authorization to Access Historical Prescription Information**

I hereby authorize the medical providers of Antonio A. Flores, M.D. P.A. to access my historical prescription drug information.

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Patient Signature: Date:

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Guardian Signature: (If applicable)