**OMAR TURK, MD**

Neurologist- Board Certified

NEUROSLEEP CENTER

*E-PRESCRIBING CONSENT FORM*

I hereby authorize Dr. Omar Turk at Neurosleep Center clinic to prescribe and refill medications through a computerized e-prescribing system. I understand that my physician may be sending m prescription(s) electronically, and I have been informed of the process.

Patient Name (Last, First): _____

Preferred Pharmacy: _____

Pharmacy Address: _____

I, _____ give Neurosleep Center permission to verify my

Medication History.

Patient Signature: _____ Date: _____

***4190 24th Ave, Ste 210, Fort Gratiot, MI 48059 Tel: 810-216-1901 Fax: (810) 216-1701***