AUTHORIZATION
FOR THE USE AND DISCLOSURE
OF
PROTECTED HEALTH INFORMATION

TO: _____
Pharmacy Name

_____
Street Address

_____
City State ZIP

A. Authorization I, the undersigned Patient, (or the Patient's Personal Representative) authorize the Pharmacy named above to disclose my Protected Health Information ("PHI") that is in the Pharmacy's possession or control to the Recipient named below strictly in accordance with the directions contained in this Authorization.

B. Re-Disclosure *(Delete whichever sentence does not apply.):* (1.) I understand the PHI disclosed pursuant to this Authorization may be re-disclosed by the Recipient, and that such re-disclosure may end my HIPAA PHI protection. (2.) This Authorization does not permit re-disclosure by the recipient.

C. Revocation I further understand that I have the right to revoke this Authorization in writing, in the form attached, but that any actions already taken in reliance on this Authorization will not be reversed and my revocation will not affect such actions.

D. Patient

Name: _____

Street Address: _____

City, State, Zip: _____

Phone/Cell: _____

Date of Birth: _____ SSN:_____

E. Recipient

The PHI is to be disclosed to the following who has agreed to pay the Pharmacy the reasonable charges paid or incurred in providing the copies of the Patient's PHI:

Name: _____
Please Print Full Name

Street Address: _____

City, State, Zip: _____

Phone/Cell: _____

E-Mail: _____

Fax: _____

F. Description The minimum necessary PHI to be disclosed is described as follows:

_____

_____

_____

G. Purpose(s) The above described PHI is disclosed solely for the following purpose(s):

_____

_____

_____

H. Duration This Authorization shall be in effect for a period of _____ next following the date of my signature (or the signature of my Personal Representative) unless sooner revoked in the manner described above.

_____
Signature of Patient or Patient's Personal Representative

_____
Date

Please describe the source of the Personal Representative's authority to sign for the Patient, e.g. Parent of an unemacipated minor, or Parent in *Loco Parentis*; or if appointed as custodial Parent, Guardian, Executor, or Administrator and the like. Please attach copies of the documents of appointment.

_____

_____

REVOCATION OF AUTHORIZATION

The foregoing Authorization dated _____ may be revoked by the Patient or the Patient's Personal Representative by completing this Revocation and delivering it to the Pharmacy in hand or by certified mail return receipt requested, or by a recognized courier service that provides proof of delivery.

Please Note: This Revocation must be received by the Pharmacy at least two business days prior to the below Revocation date in order to prevent any further disclosures pursuant to the Authorization.

The attached Authorization is hereby revoked effective at midnight on _____.
Date

_____
Signature of Patient or designated Personal Representative

Date: _____

DATE RECEIVED: _____

_____
Pharmacy Name

By: _____
Name Title