

Attention Patient:

In order to receive your prescription records, you must complete the following form entirely and return it to the pharmacy.

Thank you,

Pharmacy Staff

**AUTHORIZATION FOR RELEASE OF PHARMACY RECORD INFORMATION**

I HEREBY AUTHORIZE **INTEGRIS PROHEALTH PLAZA PHARMACY** TO RELEASE THE FOLLOWING INFORMATION:

Patient's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone No. (\_\_\_\_) \_\_\_\_\_

DESCRIPTION OF INFORMATION TO BE RELEASED: **PRESCRIPTION RECORDS**, FOR THE FOLLOWING TIME PERIOD.

FROM \_\_\_\_\_ TO \_\_\_\_\_

PERSON/ENTITY INFORMATION IS TO BE RELEASED TO:

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

PURPOSE OR NEED FOR THIS DISCLOSURE: \_\_\_\_\_

**I UNDERSTAND THAT I CAN REVOKE THIS AUTHORIZATION AT ANY TIME PRIOR TO ACTION BEING TAKEN DUE TO THIS AUTHORIZATION FOR RELEASE. I UNDERSTAND THAT THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).**

**NOTICE TO RECIPIENT OF COPIES OF ALCOHOL AND DRUG ABUSE RECORDS**

**PROHIBITION ON RE-DISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATION (42 CFR PART 2) PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION HELD BY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG PATIENT. FEDERAL REGULATIONS STATE THAT ANY PERSON WHO VIOLATES ANY PROVISION OF THIS LAW SHALL BE FINED NOT MORE THAN \$500.00 FOR THE FIRST OFFENSE OR \$5,000 IN THE CASE OF EACH SUBSEQUENT OFFENSE.**

I UNDERSTAND THAT ONCE THE INFORMATION IS DISCLOSED PURSUANT TO THIS AUTHORIZATION, THERE IS A POTENTIAL FOR RE-DISCLOSURE OF THE INFORMATION BY THE PARTY RECEIVING IT AND FEDERAL PRIVACY LAWS MAY NO LONGER PROTECT IT FROM FURTHER DISCLOSURE. **INTEGRIS PROHEALTH PLAZA PHARMACY** and its employees are hereby released from liability as a result providing the requested confidential information upon receipt of this authorization.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

In the event the patient is deceased, a minor, or mentally incapacitated, consent may be given by a legally authorized representative, identified below:

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_

This consent form will be honored only for this specific request.

