FULMER U-Save PHARMACY
Professional Compounders
"Your Problem Solving Specialists"

Patient Authorization for Disclosure of Protected Health Information

Patient: Legal Name: _____

Identification: Date of Birth: _____

Parents/Previous Name(s): _____

Provider: (Who is releasing The information sent) Name: _____

Address: _____

Information to Be Released (Check all that apply)
- ☐ Complete Medical Record ☐ Immunization Records
- ☐ Medical Records generated from the following treatment date (s) _____
- ☐ Specific Medical Records _____

Purpose:
- ☐ Transferring Medical Care
- ☐ **Second Opinion or Specialty Care**
- ☐ Litigation ☐ Insurance Claim
- ☐ Other _____

All information and Records will be sent to:

Fulmer U-Save Pharmacy
Attn: Kim Fulmer RPh
1317 Hill Street
Holdrege, NE 68949
Fax: (308) 995-6106

Prohibition on Conditioning of Authorization: I understand my pharmacist will not condition treatment on my signing this authorization, unless I am receiving research-related treatment or the only reason the clinic is providing me with health care is to make a report to a third party, such as my employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information disclosed according to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law. Federal law (42 C.F.R. Part 2) prohibits redisclosure of records from federally-assisted substance abuse program without express written consent of the patient.

Revocation: I understand that I may revoke this authorization at any time by notifying my pharmacist in writing by sending a letter or a completed Revocation of Authorization form to the manager of the pharmacy at which I receive health care. I understand that if I revoke this authorization, it will not affect any actions that my pharmacist took before my revocation letter was received. For example, my pharmacist cannot rescind disclosures that have already been made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is Binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in my physician's Notice of Privacy Practices. A fax or photo copy of this authorization shall be considered valid as the original.

_____ _____

Signature of patient or personal representative *Date*

Printed name & relationship of personal representative, if applicable _____