AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

This is an authorization consistent to HIPAA privacy rules for authorizing the release of medical and health information to a spouse, parent, adult child, friend or caregiver. They would be allowed access on an on-going basis to assist with your care and maintaining your information. You understand these records may contain information created by other persons or entities, including physicians or any other health care professionals, as well as information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services (excluding psychotherapy notes), reproductive health services and the treatment of sexually transmitted infection.

Please complete this form and return it via fax, email or in the provided prepaid mailing envelope to:

Fax: 515-265-5431• Email: NSPshipping@nucara.com • 5042 Maple Drive Pleasant Hill, IA 50327

Patient Information

First Name, Middle Initial, Last Name: ____

Date of Birth: ______________________

May we contact you via *email*? **Communication would include but not be limited to refill reminders, medication consultations, medication package tracking information and patient satisfaction surveys.**

Yes ☐ No ☐

If yes, provide email: ____

Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

Person Authorized to Receive Information from NuCara Specialty Pharmacy

Provide the information of the person who you are authorizing to receive your Protected Health Information ("PHI").

First Name, Last Name: ____

Cell Phone#: ___________________ Home Phone#: _____________________

Relationship to Patient: ____

Information Regarding this Authorization

- You have the right to revoke the authorization, in writing, to NuCara Specialty Pharmacy at any time. The revocation is only effective after it is received and logged by NuCara Specialty Pharmacy. Any use or disclosure made prior to a revocation is not included as part of the revocation.
- Refer to our Notice of Privacy Practices for permitted use and disclosures of Protected Health Information (PHI). You may obtain a copy of this notice from the corporate office. Please keep a copy of the authorization for your records.
- Once PHI is disclosed to others, it may be re-disclosed to them to persons or entities that are not subject to the privacy regulations. This means that the PHI may no longer be protected by regulations.
- Privacy regulations prohibit the conditioning of treatment, payment, enrollment or eligibility for benefits on signing this authorization.
- This authorization must be signed and dated by the patient or signed and dated by the patient's personal representative and include a description of that person's ability to act on behalf of the patient.

Patient Signature and Date

I, (print name) ______________________, by signing below, authorize NuCara Specialty Pharmacy to use or disclose my protected health information as described above.

Signature: _____________________________ Date: ______________________________

This authorization will expire on 12/31/2025

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

Only complete this section if you are a legal representative for this patient.

Example: Power of Attorney

Proof of legal representation must be included.

Legal Representative's First Name, Last Name: ____

Cell Phone#: ___________________________ Home phone#: _____________________________

Relationship to Patient: ____

Type of Documentation Included: ____

~~~~~~

This Space is for Pharmacy Purposes only.

Legal documentation received? Yes ☐ No ☐

If yes, scan documentation into patient profile.
~~~~~~