HIPAA Authorization to Release Protected Health Information
Ohio Northern University, HealthWise

I, _____, hereby authorize
[Patient name]
the use or disclosure of my protected health information as described from the facility listed below:

ONU HealthWise Pharmacy 511 W. Lincoln Ave. Ada, Ohio 45810 419-772-3784

1. Patient information

Name	DOB
Address	Phone number

2. Authorized persons to use and disclose protected health information (requestors)

Please list any individual you would like the pharmacy and clinic to be able to discuss or disclose your protected health information with.

Name _____ Relation to patient _____ Phone number_____

Name _____ Relation to patient _____ Phone number_____

Name _____ Relation to patient _____ Phone number _____

The individuals listed above are authorized to disclose of all my protected health information contained in my patient records at ONU HealthWise.

3. Description of information to be disclosed

The health information that may be disclosed is: prescription records, insurance claim records, care notes, appointment notes, lab values, and all treatment records. This information may be disclosed in writing, in person, or over the phone.

4. Purpose of this disclosure or use

This disclosure is at the request of the patient. This form allows you to authorize other individuals to access your protected Health Information. You can authorize the release of you PHI maintain by ONU HealthWise. This authorization will only apply to the health care services indicated above.

5. Validity of the authorization form

This authorization form is valid beginning on the date signed and expires 1 year after that date. This should be renewed annually with each patient.

6. Acknowledgement

I understand that the information used or disclosed under this Authorization form may be subject to re-disclosure by the person (s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization in writing at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Printed Name: _____ Date: _____

Signature: _____

HealthWise
PHARMACY