AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.

Please submit a separate Authorization for Release of Protected Health Information for each Member for whom Prescription Mart is being requested to disclose protected health information to a third party. If this form is not filled out in its entirety, Prescription Mart will be unable to process your request. Incomplete authorization requests will be returned.

1. Name of Patient or Individual

Last Name		First Name	Middle Initial
I.D. Number	Social Security Number	Birth Date (*MM/DD/YYYY*)	Daytime Telephone Number *(include area code)*
Street Address		City, State and ZIP Code	

2. Check the following box if you are requesting information to be transmitted by electronic means (ex: fax or email), including to yourself. *(Note: state law requires this form to be authorized with every electronic disclosure.)*

☐ Please release my protected health information by electronic means. I am aware the use of electronic means, including faxes or emails, may come with additional vulnerabilities and risks to incidental disclosures of my information.

3. I authorize the individual(s) or company(ies) identified below to receive PHI pertaining to the Member identified above.

Individual or company authorized to receive PHI		Daytime Telephone Number *(include area code)*
Street Address	City, State and ZIP Code	
Individual or company authorized to receive PHI		Daytime Telephone Number *(include area code)*
Street Address	City, State and ZIP Code	
Individual or company authorized to receive PHI		Daytime Telephone Number *(include area code)*
Street Address	City, State and ZIP Code	

4. Purpose(s) for this Authorization:

The purpose of this authorization is to allow disclosure for PHI to the above authorized individuals only. Complete the following by indicating those items that you want disclosed. If all health information is to be released, you may check the first item.

____ **All health information**
____ Statement of charges or payments
____ Record of all prescriptions filled, including name of medication and amount paid
____ Copies of records or reports
____ Consultation reports
____ Other_____

Initials are also required to release the following types of information:

____ HIV/AIDS Test Results or Treatment
____ Drug, Alcohol, or Substance Abuse Records
____ Genetic Information (including Genetic test results)
____ Mental Health Records (excluding psychotherapy notes)

5. IMPORTANT: Your signature below means you understand and agree to the following:

- I hereby voluntarily authorize Prescription Mart to disclose, communicate or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.
- The PHI disclosed pursuant to this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually transmitted diseases, and/or HIV/AIDS.
- Any and all records, whether written, oral or electronic in format, are confidential and cannot be disclosed without the patient's prior written authorization, except as otherwise provided by law.
- This authorization may be revoked at any time, except where information has already been released, by notifying Prescription Mart in writing at the address below.
- PRESCRIPTION MART, its employees, officers and pharmacists are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- Treatment, payment or eligibility for benefits may not be conditioned upon obtaining this Authorization, however, without a signature, information cannot be released to the party or parties named in Section 2.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.
- You may receive a copy of this signed form if requested.
- If we receive requests for copies of claims and encounter information from the individual or company you have named in Section 2, we may charge a reasonable fee to cover our copying and mailing costs.

6. Signature of Member or Member's Legal Representative

- **If the patient is 18 years of age or older,** the patient must sign and date this form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date this form.
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date this form, unless an exception exists under state or federal law.

Signature	Date

Printed Name

If the person signing the Authorization is not the Member, describe the relationship to the Member (*Parent, Legal Guardian, Legal Representative, etc.)*

If this authorization is being signed by the Member's Legal Representative, you must furnish a copy of the health care power of attorney, or other relevant documentation authorizing you to act on the Member's behalf.

Return this completed form and relevant documentation, if necessary, to:

Prescription Mart
PO Box 12607
Beaumont, TX 77726
Fax: (409) 866-1317