Request to Access or Release Protected Health Information

Patient Name: _____ Date of Birth: ___/___/_____

Address: _____

Release PHI To:

☐ Self: ☐ Pick up ☐ Review on site ☐ Mail (address above) ☐ Email: _____

☐ Picked up by the following authorized individual: _____

☐ Send to: Name of Recipient: _____

Address and/or Fax: _____

_____

Dates of PHI to Release: ___/___/_____ through ___/___/_____

PHI Requested:

☐ Prescription Fill History (specify Rx#, drug, condition or all): _____

☐ Billing Records (specify Rx#, drug, condition, or all): _____

☐ Other Records (specify which records or record types): _____

_____

_____

Reason for the Request:

☐ Medical Care ☐ Legal Action/Investigation ☐ Insurance Payment/Eligibility/Benefits

☐ Taxes ☐ Personal ☐ Other: _____

Expiration of Request: This authorization shall remain in effect until:

☐ Date: ___/___/_____ ☐ Once ☐ One (1) Year ☐ Other Event: _____

I acknowledge that I have the right to inspect and receive a copy of the health information I have authorized to be used or disclosed by this form. I understand that Soldotna Professional Pharmacy may charge a fee for the costs of copying, mailing or other supplies to respond to this request. I also acknowledge that I may modify or terminate this authorization in writing at any time. I understand that any modification or termination will not apply to uses or disclosures that have already occurred based on prior authorization or any use or disclosure that is required or permitted by law. I further acknowledge that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy law.

_____ ___/___/_____

Signature of Patient or Personal Representative — Date

_____ _____

Personal Representative (Print) — Relationship to Patient