BELLEVUE DRUG CO., 254 BELLEVUE AVENUE, HAMMONTON, NJ 08037
Phone: 609.561.0825 Fax: 609.561.9578 www.bellevuedrug.com

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

By signing below I authorize Bellevue Drug Company and/or its authorized agents to release my dependents' and/or my own personal health information to my authorized representative or me.

IMPORTANT: Any individual 18 years of age or older is required to sign this document personally. A parent or legal guardian may sign on behalf of dependent children.

Please complete all sections: Today's Date: _____

Name: _____ Phone #_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Please indicate name and relationship of individual(s) authorized to receive PHI or be contacted on your behalf:

NAME_____RELATIONSHIP_____

ADDRESS/PHONE #_____

REPORT TYPE: (Please check one)

_____ ($) Total Only Report (Income Taxes, etc.) From:_____To:_____

_____ Detail Report (Provides Rx Detail) – From:_____To:_____

Most requests will be ready for pickup within 3 business days.

Please note: a processing fee of $3.00 will be charged for multiple requests of health records.

Please list below the names and dates of birth for all individuals requesting prescription history or personal health information followed by the appropriate corresponding signature. ***(Reminder: if patient is 18 yrs. of age or older, they are required to sign release.)***

Print Name	Birth date	X Signature of Patient Required if over 18 yrs.
_____	_____	X_____
_____	_____	X_____
_____	_____	X_____
_____	_____	X_____

For Office Use Only

Date Processed _____ Completed By _____

Updated: 1/18/12