



Tampa Family Pharmacy  
 DBA: TFP Wellness Systems  
 12470 Telecom Dr. Suite 110W, Tampa, FL. 33637  
 Phone: 813-813-5161 | Fax: 813-877-2479  
 Email: Advocate@tfpspecialty.com

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

In accordance with the Federal Government privacy rules implemented through the Health Insurance Portability and Accountability Act (HIPAA), for our pharmacists or staff to be able to discuss your conditions and/or medications with your family members or other individuals that you designate, we must obtain your signed authorization.

This authorization to release your information will expire on the date specified below. It is your responsibility to inform us in writing if you wish to update or change this information.

I authorize TAMPA FAMILY PHARMACY to release any or all information concerning my medical/prescription care to the following individuals:

First Name	Last Name	Relationship	Phone #	Authorization Expiration Date
1.				
2.				
3.				

**\*\*Please Note\*\*:** You may choose the expiration date for each individual listed above. The date selected is based on your preference, and the authorization will remain valid until that date.

**I DO NOT authorize Tampa Family Pharmacy to release any of my protected health information with any individual.**

I understand that I can cancel this consent at any time by writing to Tampa Family Pharmacy. This authorization will be in effect until the expiration date input above.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_