AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Authorization for use or disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act)

PATIENT INFORMATION

Name: _____ Date of Birth:_____

Address: _____

City: _____ State: _____ Zip Code: _____

AUTHORIZATION

I authorize American Service and Product, Inc (aka - ASAP Pharmacy) to use or disclose my protected health information (PHI) to and from the following authorized person(s):

_____

Name Phone Number

_____

Email Relationship

_____

Name Phone Number

_____

Email Relationship

DELIVERY METHOD

I authorize my information to be disclosed via:

- ❑ Phone
- ❑ Email
- ❑ Text

- I understand that I can request a copy of this authorization.
- I understand that I have the right to revoke this authorization at any time. I understand that my refusal to sign or revocation will not affect my treatment from ASAP Pharmacy. I understand that my revocation is only effective after collected and logged by ASAP Pharmacy.
- I understand that the information used or disclosed pursuant to this authorization may be disclosed to the recipient and may no longer be protected by state or federal law.
- I understand that I am entitled to request and receive a copy of this authorization.
- I understand that if my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the person or entity that receives my information. I understand that this re-disclosure may not be protected by HIPAA, state, or federal laws.

_____

Signature of Patient **Date**

_____

Printed Name of Patient

Please return the form to priti@wecareasap.com or fax to 708-448-8598 or mail to 16612 107th Ct., Orland Park, IL 60467