227 Main Street
Fort Fairfield, ME 04742
Phone: 1-888-422-7319 Fax: 1-877-422-7319

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
TO PERSONAL REPRESENTATIVE

Note: This authorization may not be used for the release of psychotherapy notes or for release of health information for marketing purposes.

I , ________________________________ [Name] Date of Birth _______________ hereby authorize I Care Pharmacy to:

____ use the protected health information describe below, and/or
____ disclose the protected health information below to:
____ disclose financial/co-pay information only

____________________________ [Personal Representative's Name]

(Check the appropriate line or lines above, then fully and completely describe the information that may be used or disclosed below. Include such information as dates of health services involved, the type of service provided, names of doctors, hospitals, etc., and the amount of detail that may be used or disclosed.)

____
____
____
____

I want this authorization to expire, and it will no longer be effective on ___________ [insert date], or upon the following event: _______________________________________.
(If you would like, you may list an event that relates to you this or the purpose of the use/disclosure, which will cause the authorization to expire. If no event is listed, the authorization will expire on the date you list. If this authorization pertains to participation in a research study, "end of research study" or "none" is sufficient.)

If you have any questions, please feel free to contact us at 1-888-422-7319.

___________________________________ _____/_____/_____
Patient Signature Date

IMPORTANT INFORMATION
PLEASE READ CAREFULLY!

I understand that I have a legal right to revoke this authorization only by writing to the Privacy Official at the following address:

Privacy Official
I Care Pharmacy
227 Main Street
Fort Fairfield, ME 04742