MEN'S HEALTH FOUNDATION PHARMACY	**Authorization to Release Health Information**

This form is used by a Patient or Patient's Representative to authorize Men's Health Foundation Pharmacy ("Pharmacy") to release health information to an individual or organization not otherwise authorized by law to receive it, as required by the Health Insurance Portability and Accountability Act ("HIPAA") and other state and federal privacy laws.

Section 1: Patient Information

Patient Name:			Date of Birth:
Address:			
City:	State:	Zip:	Phone:

Section 2: Information to be Released

a. I authorize the release of the following health information: ☐ Specific Prescription(s): ☐ Medical Expense Summary (List of all prescription expenses) ☐ Designated Record Set (Entire medical record maintained by the Pharmacy)
b. For the following dates of service: ☐ All dates of service: ☐ From _______ to _______

Section 3: Recipient and Purpose

Recipient Name:	Phone:
Name of Organization:	
Address:	
City, State, Zip:	
The purpose of this Authorization is:	☐ At the request of the Patient/Patient's Representative ☐ Other (state reason):

Section 4: Specific Consent

a. I understand that my patient profile may include information related to treatment of **mental health conditions, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases, or communicable diseases.** I understand that the information, if any, pertaining to any of the conditions described above may be released. Please initial the statement that applies (you must initial one): ____ I do authorize the release of this specific information ____ I do **not** authorize the release of this specific information

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Section 4: Specific Consent, Continued

If I authorize the release of this specific information, the recipient is prohibited from redisclosing this information without written authorization by me or my personal representative, unless permitted to do so under federal or state law.

Complete the following section ONLY if you indicated that you do not authorize the release of specific health information related to treatment of **mental health conditions, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases, or communicable diseases.**

b. In order for the Pharmacy to exclude information related to treatment of **mental health conditions, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases, or communicable diseases,** I must list specific drugs and/or prescription numbers that should not be released.

Drug Name/Rx #	Date Range

Drug Name/Rx #	Date Range

Section 5: Expiration Date of Authorization

This authorization will remain in effect under the following conditions: (check one)

☐ Until the following date:
☐ Until the following date occurs:
☐ One year from the date of my signature below.

Section 6: Signature

a. I understand that signing this Authorization is voluntary. Receipt of Pharmacy services will not be conditioned upon my authorization of this disclosure.
b. I understand that if I authorize the release of my health information to a recipient who is not legally required to keep it confidential, the information may be redisclosed and may no longer be protected by federal or state privacy laws.
c. I have the right to revoke this Authorization in writing at any time.

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____

Signature of Patient or Personal Representative

____

Today's Date

If you have signed this form as a legally authorized representative of the Patient, please print your name and relationship to the Patient below.

____

Name of Personal Representative

____

Relationship to Patient
(parent, legal guardian, etc.)