AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION TO PHARMACY REPRESENTATIVE

This authorization is for use, pursuant to the HIPAA privacy rules, if you are authorizing the release of medical or health information to a spouse, parent, adult child or caregiver for access on an on-going basis to assist with your care and maintaining your information.

You understand these records main contain information created by other persons or entities, including physicians or any other health care professionals, as well as information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services (excluding psychotherapy notes), reproductive health services and the treatment of sexually transmitted diseases.

Section 1: Patient Information

First Name, Middle Initial, Last Name: ______________________________

Date of Birth MM/DD/YEAR: __________/__________/__________

Street Address: ______________________________ City: ____________________

State/Zip code: ______________ Telephone: (________) ____________________

Section 2: Person Authorized to Receive Information from River's Edge Pharmacy

First Name, Middle Initial, Last Name: ______________________________

Date of Birth MM/DD/YEAR: __________/__________/__________

Street Address: ______________________________ City: ____________________

State/Zip code: ______________ Telephone: (________) ____________________

Email Address: ____

Relation to Patient: ____

Section 3: Information to be Released

Describe or list the information that you are asking us to release to the above named person. Initial here if any and all prescription information related to medical and health services received by River's Edge Pharmacy

Patient Initials: ____________