



Saliba's Skilled Care Pharmacy

Authorization for Use or Disclosure of Protected Health Information

Name of Patient: _____ Date: _____

I hereby authorize the use and disclosure of my health information as indicated below. I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

I hereby authorize the release of the information checked and/or listed below for the time period beginning on _____ and ending on _____:

- | | |
|---------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Complete health care record(s) | <input type="checkbox"/> Prescription Records |
| <input type="checkbox"/> Consultant Pharmacist Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Billing Statements | <input type="checkbox"/> Care Plans |
| <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Other: _____ | |

The information checked and/or listed above is to be released to: _____
for the following purpose(s): _____
_____.

I understand that the individual, organization, or entity receiving my health information may provide financial or in-kind compensation to the [pharmacy/pharmacist] in exchange for the use of the disclosed information described above.

Unless otherwise revoked by me, I understand that this authorization will expire on _____ or upon the completion of the use of the information for the purpose it was intended, whichever is earlier.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or prescription drugs, payment or eligibility for benefits, unless my treatment or prescription drugs are part of a research study and the authorization would enable the above-identified information to be used for such research.

I understand that I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services.

I hereby release the above-named entity, its employees, officers, and health care professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I may revoke this request at any time by providing the above-named entity with my written notice of such revocation.

Date: _____

Signature of Patient: _____

Printed Name of Patient: _____

Date: _____

Signature of Representative: _____

Printed Name of Representative: _____

Relationship to Patient: _____