

AUTHORIZATION FORM TO RELEASE PROTECTED HEALTH INFORMATION FOR PURPOSES OTHER THAN PAYMENT, TREATMENT OR HEALTHCARE OPERATIONS

PURPOSE: For release of protected health information to a third party not involved with the payment, treatment or health care operations of the patient.

I, _____, born on _____, authorize the use and/or disclosure of my protected health information ("PHI") as described below:

1. Only the following PHI may be used/disclosed pursuant to this Authorization:

2. Only the following person(s) or classes of persons are authorized to use/disclose my PHI pursuant to this Authorization: _____
3. Only the following person(s) or classes of persons are authorized to receive my PHI pursuant to this Authorization: _____
4. My PHI will be used/disclosed only for the following purposes (list and describe each purpose): _____
5. I understand I may revoke this Authorization in writing at any time by sending a letter to: Millers of Wyckoff, 678 Wyckoff Avenue, Wyckoff, NJ 07481 except to the extent the Pharmacy has already taken action in reliance on this authorization.
6. I understand I may refuse to sign this Authorization and my refusal to sign will not affect my ability to obtain treatment from the Pharmacy.
7. I understand if the person or entity that receives my PHI is not required to comply with the federal privacy regulations, the information described above may be redisclosed and would no longer be protected by those regulations.
8. I understand the Pharmacy may receive compensation for using/disclosing my PHI pursuant to this Authorization.
9. This Authorization expires _____.

Signature of Patient or Personal Representative

Date Signed

Print Name of Person Signing

Signer's Date of Birth

If signed by the patient's personal representative, explain your authority to act on behalf of the patient:

NOTE: Form must be completed in its entirety (no blank lines) before any action will be taken.