West Milford PHARMACY GIFT

Request to Access or Release Protected Health Information

Patient name:_____ Date of birth:_____/_____/_____

Address:_____

Release PHI to:

☐ Self: → ☐ Pick up ☐ Review on site ☐ Mail (address above) ☐ Email*:_____
☐ Picked up by the following individual:_____
☐ Send to: Name of recipient:_____
Address, fax, or email*:_____

Dates of PHI to release:_____/_____/_____ through _____/_____/_____

PHI requested:

☐ Prescription fill history (specify Rx # or all):_____
☐ Billing records (specify Rx # or all):_____
☐ Other records (specify):_____

Reason for request:

☐ Medical care ☐ Taxes ☐ Insurance payment/eligibility/benefits ☐ Legal
☐ Personal ☐ Other:_____

Expiration of request: This authorization shall remain in effect until:

☐ Just this once ☐ The following date:_____/_____/_____

I acknowledge that I have the right to inspect and receive a copy of the health information I have authorized to be used or disclosed by this form. I understand that West Milford Pharmacy may charge a fee for the costs of copying, mailing, or other supplies to respond to this request. I also acknowledge that I may modify or terminate this authorization in writing at any time. I understand that any modification or termination will not apply to uses or disclosures that have already occurred based on any prior authorization or on any use or disclosure that is required or permitted by law. I further acknowledge that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy law.

_____ _____/_____/_____
Signature of patient or personal representative Date

_____ _____
Personal representative (print) Relationship to patient

*Email is not a secure form of communication