Authorization for Disclosure of Protected Health Information

Authorization for Disclosure of Health Information

This information is used to use/disclose/obtain your protected health information as required by federal and state privacy laws. Your authorization allows East Alabama Apothecary Specialty Pharmacy to use or obtain your protected health information and to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to East Alabama Apothecary Specialty Pharmacy. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Part A. Patient Information

Patient's Name			Date of Birth
Street Address	City	State	Zip Code
Phone Number	Email Address		

Part B. Authorization

☐ I authorize East Alabama Apothecary Specialty Pharmacy to disclose my protected health information as described below.

Part C. Recipient Information

The following individual or company has the right to receive my information (they must be 18 years of age or older).

First Name/Company Name	Last Name		
Street Address	City	State	Zip Code
Phone Number	Relationship to Patient		

Part D. Description of the Information to be Released:

I allow the following information to be used or released by East Alabama Apothecary Specialty Pharmacy on my behalf:

☐ **All My Information.** This can include health, diagnosis (name of illness or condition), claims, doctors and other health care providers and certain financial information (such as premium billing and payment). This does not include sensitive information (see below) unless it is approved below.

☐ **Only Limited Information** (check all boxes below that apply):

- ☐ Lab test results
- ☐ Benefits and coverage
- ☐ Claims, billing, and payments
- ☐ Prior authorizations (for treatment approvals)
- ☐ Medications
- ☐ Diagnosis (name of condition and treatment)
- ☐ Other: ____

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Part E. Expiration Date of this Approval

This authorization will:
☐ never expire, unless revoked in writing
☐ expire on the following date: ____ / ____ / ________
☐ expire upon the following event: ____

Part F. Approval

I understand that this authorization for disclosure of health information is voluntary and is not a condition of utilization of East Alabama Apothecary Specialty Pharmacy. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected under federal or state privacy laws. I understand that I may revoke this authorization at any time by notifying East Alabama Apothecary Specialty Pharmacy in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.

Patient/Representative Signature

Signature of Patient/Representative	
Print Name	Date
Relationship of Representative to Patient (if applicable)	