Pequot Health Care
HIPAA AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Patient Name:_____ **Date of Birth**: _____

Primary Cardholders SS#:_____ **Card Member ID# (alternate ID):** _____

I,_____, hereby authorize Pequot Pharmaceutical
(Print patient name)
Network (PRxN) to release my pharmacy records/information to:

Name of Recipient: _____

Address: _____

(to which it should be mailed) _____

The information to be used/disclosed consists of: (Please include time period of requested information)

Note: This description must be specific and meaningful.

The information will be used/disclosed for the following purposes:

This authorization for is for one time use ONLY or valid until authorization expiration below. Unless otherwise specified in writing, information may be disclosed in electronic, hard copy or other form.

I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

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 payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

The authorization expires:_____[insert applicable date or event]. If responding with a date, please allow PRxN adequate time (at least 15 days) to process this request and provide a response.

_____ _____

Signature of Patient/Client Date

or his/her authorized representative, or parent or guardian if a minor, please specify relationship to patient/client. If a representative signs, describe the representative's authority to act on behalf of the patient.

Please submit form by: Dropping off in person at the Main Pharmacy or Mail to 1 Annie George Drive, Bldg. 1, Mashantucket, CT 06338

PHI disclosed to:_____ ID verified: _____ PHI disclosed by: _____

COMPLETION OF ALL HIGHLIGHTED AREAS IS REQUIRED