Pequot Pharmaceutical Network

HIPAA AUTHORIZATION FOR RELEASE OF PATIENT RECORDS
Pharmacy Benefit Management/Mail Service Division

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

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 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

PHI disclosed to: _____ ID verified: _____

PHI disclosed by: _____

FOR OFFICE USE ONLY

COMPLETION OF ALL HIGHLIGHTED AREAS IS REQUIRED