Rx Outlet

AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS

I, _____ who resides at _____

In the city of _____ in the state of _____ hereby authorize:

Mail to: **Rx Outlet**
10 Meadowlands Parkway
Secaucus, NJ 07094

to disclose the following specific health information by ☐ mail or ☐ fax or ☐ e-mail to:

Name: _____
(Physician, Hospital, Clinic, or other Healthcare Provider, Healthplan, Third Party Admin, Other Payer or Other Party)

Address: _____

City, St., Zip: _____

From the Health or Prescription Drug Records of:

Name: _____
(Name of Individual Whose Health or Prescription Drug Record is Being Disclosed)

Address: _____

City, St., Zip: _____

For the purpose of: _____

My authorization extends only to those data elements/documents initialed below:

_____ Statements of charges or payments
_____ Record of all prescriptions filled including name of medication and amount paid
_____ Record of all pharmaceuticals dispensed
_____ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc)
_____ Consultation Reports
_____ All of the above
_____ Other (Must be specific) _____
_____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below.
4. DrugSource, Inc., its employees, officers, and pharmacists are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____

Patient's Name Printed Date

_____ _____

Patient's Signature (Or Guardian, If a Minor) Expiration Date (If Other Than 1 Year From Date Above)

_____

Social Security Number (For Identification Purposes Only)

_____ _____

Witness Date