HIPAA RELEASE AND AUTHORIZATION OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

I hereby authorize PHIL PHARMACY SOLUTIONS LLC to disclose my Protected Health Information (PHI) the following person to act as my agent with regard to the matters specified in this Release:

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Relationship to Patient: _____

Email, if applicable _____

Additional authorized contacts, if desired:

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Relationship to Patient: _____

Email, if applicable _____

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Relationship to Patient: _____

Email, if applicable _____

For purposes of this Release, the following persons shall also be treated as my agents in addition to the persons listed above: (i) any person designated as a primary or successor agent in a durable power of attorney or advance health care directive which I have executed, whether or not such person is presently serving as such; (ii) any person presently serving as trustee or named as a successor trustee in any revocable or irrevocable trust created by me as grantor; and (iii) any successor custodian I have named on a Uniform Transfers to Minors Account, Uniform Gifts to Minors Account, Section 529 Account, or other similar minor's account.

This Release and all of the provisions contained herein are effective immediately. I intend for my agent to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This Release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. Sections 1320d to 1320d-9 and 45 C.F.R. Sections 164.500 to 164.534, as may be amended from time to time.

AUTHORIZATION

I hereby authorize any doctor, physician, medical specialist, psychiatrist, chiropractor, health-care professional, dentist, optometrist, health plan, hospital, hospice, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, pathologist, or other provider of medical or mental health care, as well as any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has paid for or is seeking payment from me for such services (referred to herein as a "Covered Entity"), to give, disclose and release to my agent who is named herein and who is currently serving as such and without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to access any protected medical information to my agent. Health information and medical records as indicated above shall be released at my request or at the request of my agent named herein as may be needed to assist in my treatment, make decisions about my care or for any other reason, at my discretion or at the discretion of my agent.

In determining whether I am incapacitated, all individually identifiable health information and medical records shall be released to my agent, including any written opinion relating to my incapacity that my agent may have requested. This release authority applies to any information governed by HIPAA and applies even if my agent has not yet begun serving as my agent.

The authority given to my agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to my agent may be subject to re-disclosure by my agent and may no longer be protected by HIPAA.

OPTIONAL EXCLUSION OF SENSITIVE RECORDS:

I understand that my health records may include information related to mental health services, psychiatric care, substance use disorder (SUD) diagnosis and treatment, or psychotherapy notes, which may be protected under federal and state law, including but not limited to 42 C.F.R. Part 2 and applicable mental health privacy laws.

☐ **I DO NOT authorize** the release of any information related to mental health, psychiatric treatment, or substance use disorder services protected under 42 C.F.R. Part 2 or state law.

☐ **I DO NOT authorize** the release of any psychotherapy notes or medications generally used in the treatment of any mental health condition.

☐ **I DO NOT authorize** the release of HIV/AIDS-related information or medications generally used in the treatment or prevention of HIV/AIDS.

I understand that by checking any of the boxes above, those types of records will be excluded from the information shared under this authorization.

TERMINATION

This authorization will remain in effect until one (1) year from the date of my signature, unless otherwise required by applicable state law. This authorization shall automatically terminate upon notification of my death.. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, electronic mail, or any other means evidencing actual receipt by the Covered Entity. This Release shall not be affected by my subsequent disability or incapacity. There are no exceptions to my right to revoke this Release.

RELEASE

Each Covered Entity that acts in reliance on this Release shall be released from liability that may result from disclosing my individually identifiable health information and other medical records.

LEGAL ACTION

I authorize my agent to bring a legal action against a Covered Entity which refuses to accept and recognize this Release. No Covered Entity may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 C.F.R. Section 164.508(b)(4) applies. Further, to fulfill my intent as expressed herein, I authorize my agent to sign any documentation that my agent deems necessary or appropriate to secure the disclosure of my individually identifiable health information and other medical records.

SUBSEQUENT DISCLOSURE OF INFORMATION

Any information disclosed to my agent under this Release may subsequently be disclosed to another party by my agent. My agent shall not be required to indemnify a Covered Entity or perform any act if information is subsequently disclosed by my agent.

COPIES, PDFs, AND FACSIMILES

Copies, PDFs, or facsimiles of this Release shall be as valid as the original Release.

SIGNATURE OF PATIENT

_____
[Signature]

Printed Patient Name: _____ Date:_____