Patient Authorization Form

This form will be retained in your medical record.

In accordance with HIPAA, applicable state laws and our Notice of Privacy Practices, Acro Pharmaceutical Services and Commcare Specialty Pharmacy (collectively and separately hereinafter "**Pharmacy**") are required to maintain the privacy of your Protected Health Information ("PHI"), including your Patient Prescription Record ("PPR").

In order for us to better protect your privacy, your PHI/PPR and account information will be discussed with those you choose to receive such information.

❖ I hereby authorize Pharmacy to disclose my PHI/PPR, reflecting my prescription history and any other Pharmacy services I have received from Pharmacy as set forth below:

a. My PHI/PPR, may be disclosed to the following person(s), categories of person(s), or entities:

- Name:____
- Address:____
- Relationship to Patient:____

- Name:____
- Address:____
- Relationship to Patient:____

b. I authorize Pharmacy to leave voicemail messages concerning my PHI/PPR at the following phone number(s):

- Phone Number:____
- Relationship to Patient:____

- Phone Number:____
- Relationship to Patient:____

❖ Purpose of the release of information:

☐ At the request of the Patient/Patient's Personal Representative.
☐ Other:____.

❖ I understand that my PHI/PPR may include information related to treatment of mental health conditions, alcohol or substance abuse, HIV or AIDS, sexually transmitted diseases or communicable diseases. I understand that the information, if any, pertaining to any of the conditions described above may be released.

☐ I authorize the release of this information.
☐ I do not authorize the release of this information.

❖ I understand that if the person or entity that received my PHI/PPR is not required to comply with the applicable privacy regulations, the information described above may be re-disclosed by the recipient and no longer be protected by those regulations.

❖ I understand that signing this Authorization is voluntary and that this Authorization will not affect my ability to obtain treatment from Pharmacy, any payment for treatment or enrollment or eligibility for benefits. A photocopy or facsimile of this signed Authorization is as valid as the original and will be accepted.

- I understand that I may revoke this Authorization at any time, except to the extent that Pharmacy has taken action in reliance on this Authorization, by writing PremierPrivacy@PremierInc.com or the following address:

Premier, Inc.
Attn: Premier Legal / Premier Privacy
13034 Ballantyne Corporate Place
Charlotte, NC 28277

- I understand that I have the right to receive a copy of this Authorization.

- This Authorization will expire 12 months from the date I sign it as shown below on this Authorization unless I enter a different expiration here _____________ or revoke as instructed above.

By signing below, I acknowledge I understand and have completed this Patient Authorization Form.

____
Signature of Patient or Personal Representative

____
Name of Patient

____
Date

If Personal Representative is signing for the patient, please provide your name, address, documentation and description of your ability to sign on behalf of the patient.

Name:____

Street Address:____

City, State, Zip:____

Telephone Number:____

E-Mail:____

Relationship to Patient: ____

For Office Use Only

I attempted to obtain written consent for disclosures of protected health information but the consent could not be obtained because:

☐ The individual refused to sign
☐ Communication barriers prohibited obtaining acknowledgement
☐ An emergency situation prevented us from obtaining the consent
☐ Other (Please specify)

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