HIPAA Privacy Authorization Form

Authorization for use or disclosure of Protected Health Information (PHI)
Required by the Health Insurance Portability and Accountability Act, 45 C.F.R 160 and 164

Patient's Name: _____ DOB: _____

Address: _____ City, St, Zip: _____

I authorize Benzer Pharmacy to use and disclose the protected health information described below

to and/or from _____

This authorization for release of information covers the period of healthcare from (timeframe):

☐ _____ to _____ **OR** ☐ All past, present and future periods.

I understand that the health information that I authorized to be used or disclosed may include information relating to sexually transmitted disease, HIV and AIDS, mental health or substance abuse.

I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and no longer protected by federal or state privacy regulations.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that my refusal to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits.

I understand that if this authorization is for the disclosure of health information for a research study, I may refuse to sign this authorization. I understand that if I refuse to sign this authorization, I may not receive the treatment related to the research study.

I understand that Benzer Pharmacy only collects PHI for the purposes stated, including but not limited to, authorization of medication and as necessary to provide services/programs that the I am eligible for.

I understand that by signing this form I am authorizing Benzer Pharmacy to contact me to provide me with information regarding Benzer services and/ or my condition and/or my treatment options.

I understand that I may revoke this authorization at any time provided that the information has not already been disclosed. Information that has already been disclosed may not be further disclosed once the authorization has been revoked. I understand that if I choose to revoke this authorization, I must do so in writing.

I understand that I have a right to request and receive a copy of Benzer Pharmacy's Notice of Privacy Practices.

A photocopy of this authorization is as valid as the original.

I understand that this authorization will expire ten (10) years from the date signed below.

_____ _____

Signature of patient **OR** Patient's personal representative Date

_____

Printed name of patient **OR** Patient's personal representative and relationship to patient