

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

1. Authorization

Printed Name	Date of Birth
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I authorize Axiom Healthcare Pharmacy (Pharmacy Provider) to use and disclose the protected health information described below to:

Name/Relationship
Name/Relationship
Name/Relationship

2. Effective Period *The dates of service covered by this authorization are:*

Start Date (MM/DD/YY)	End Date (MM/DD/YY)
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3. Extent of Authorization for the Effective Period *Choose one:*

<input type="checkbox"/> I authorize the release of specific health records as indicated here:
<input type="checkbox"/> I authorize the release of my complete health record (excluding highly confidential information).
<input type="checkbox"/> I authorize the release of my complete health record including highly confidential information as indicated below: <input type="checkbox"/> Mental health records <input type="checkbox"/> Communicable diseases (including HIV and AIDS) <input type="checkbox"/> Alcohol/drug abuse treatment <input type="checkbox"/> Other (please specify): _____

Please indicate method of delivery (*Note: There are certain risk inherent to transmission via email. We cannot guarantee security of email transmissions*):

<input type="checkbox"/> Email to:
<input type="checkbox"/> Mail to:
<input type="checkbox"/> Fax to:

4. Specific Purpose for Use/Disclosure of PHI

<input type="checkbox"/> At my request (patient or patient representative); or <input type="checkbox"/> List and describe each purpose:
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5. I understand that I am entitled to receive a copy of this authorization.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that revocation is only effective after it is received and logged by the pharmacy.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed Name of Patient or Personal Representative and His or Her Relationship to Patient	
Signature of Patient or Personal Representative	Date

Please e-mail completed form to: ksp-collections@axiumhealthcare.com.

This Authorization Form expires one year from date of signature unless previously voided through written communication from patient/patient representative.
Any documentation used to verify authority as Personal Representative must be attached.