SMITH PHARMACY
est. 2013

(HIPAA RELEASE)

REQUEST TO ACCESS OR RELEASE PROTECTED HEALTH INFORMATION

RELATIONSHIP TO PATIENT: ☐ Self ☐ Parent of Minor Child ☐ Personal Representative*

*Personal representative is an individual with legal authority to make health care decisions on behalf of the individual.

PATIENT INFORMATION

☐ Check this box if the patient is deceased.

Patient Name: _____ Date of Birth: _____

Address: _____

INFORMATION REQUESTED

(a) I request information from the 2023 calendar year (January 1, 2023 – December 31, 2023)

OR WRITE-IN REQUESTED DATE RANGE: _____

(b) I request copies of the following Protected Health Information:

☑ Medical Expense Summary / Patient IRS Statement

(PLEASE NOTE: statement lists all prescription expenses paid by patient and insurance – also contains all drug names, fill dates, and prescribers associated with each RX#)

(c) I request copies in the following format:

☐ Printed copy: Pick-up

☐ Printed copy: Mail to above address

☐ Electronic copy: Email or fax to: _____

EXPIRATION DATE OF AUTHORIZATION

This authorization will remain in effect until one year from the date of my signature below unless written notice is given to Smith Pharmacy to revoke this authorization prior to that date.

ACKNOWLEDGEMENTAND SIGNATURE

I acknowledge that I have the right to inspect and receive a copy of the health information I have authorized to be used or disclosed by this form. I acknowledge that drug names may inadvertently disclose information about health conditions and diagnoses. I also acknowledge that I may modify or terminate this authorization in writing at any time. I understand any modification or termination will not apply to uses or disclosures that have already occurred based on prior authorization or any use or disclosure that is required or permitted by law. I further acknowledge information used or disclosed pursuant to this authorization may be subject to re-disclosure and will no longer protected by state or federal privacy law. Smith Pharmacy may charge a fee for the costs of copying, mailing or other supplies to respond to this request.

_____ _____

Signature of Patient or Personal Representative Date

If you have signed this form as a legally authorized representative of the patient (parent, legal guardian, power of attorney, etc.), please print your name and relationship/authority to act on behalf of the patient.

_____ _____

Name of Personal Representative (please print) Relationship to Patient