Authorization for Release of Records

krogerspecialtypharmacy.com

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

I authorize Kroger Specialty 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)

3. Extent of Authorization for the Effective Period *Choose one:*

☐ I authorize the release of specific health records as indicated here:
☐ I authorize the release of my complete health record (excluding highly confidential information).
☐ I authorize the release of my complete health record including highly confidential information as indicated below: ☐ Mental health records ☐ Communicable diseases (including HIV and AIDS) ☐ Alcohol/drug abuse treatment ☐ 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)*:

☐ Email to:
☐ Mail to:
☐ Fax to:

4. Specific Purpose for Use/Disclosure of PHI

☐ At my request (patient or patient representative); or ☐ List and describe each purpose:

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.