AUTHORIZATION TO RELEASE HEALTH INFORMATION – OUTPATIENT PHARMACY

INSTRUCTIONS FOR COMPLETING FORM: Please write legibly and complete all sections as indicated. Return the completed and signed form to:
FirstHealth Moore Regional Hospital PO Box 3000, Pinehurst, NC 28374 ATTN: Outpatient Pharmacy or Fax to 910-715-4255

Printed Patient Name (Last, First, Middle Initial)	Birth Date (MM/DD/YYYY)	Last 4 of Social Security Number	MR# -Internal Use

Mailing Address (Include Street/PO Box, City and Zip Code)	Telephone# (Including Area Code) ( )

Date/s of Prescription/s:	Date Copies Needed By	Mail ☐ Pick-up ☐ (Positive ID Required)

I hereby authorize: ☒ Firsthealth of the Carolinas – Outpatient Pharmacy / Pinehurst, NC 28374

to release copies of pharmacy records on the above patient to ☐ myself ☐ Other (specify): _____

ADDRESS _____
(*Indicate complete mailing address if different from patient address).*

PHONE NUMBER _____ **FAX NUMBER** _____

INFORMATION TO BE RELEASED INCLUDES (*Check applicable box/s and indicate other information in the space below*.

☐ Outpatient Pharmacy Prescription/s ☐ Other (Specify)_____

_____

PURPOSE OF RELEASE_____

I understand that this authorization is voluntary and that I may refuse to sign it. I need not sign this form to ensure healthcare treatment or payment for such treatment.

This authorization is void 180 days after the date signed or anytime I, as the patient, guardian, or legally authorized representative make a **specific written request to the entity noted above to revoke** the authorization. Such revocation shall be effective *except* to the extent that the facility has already used or disclosed information in reliance on the authorization.

I am aware and understand that once information is used or disclosed based on this authorization it may be re-disclosed by the recipient and at such time may no longer be protected by federal privacy laws or regulations.

_____ _____
Signature of Patient/Individual With Legal Authority to Sign*** ***Date/Time***

_____
(Specify relationship if anyone other than patient authorizes release)

_____ _____
Signature of Witness To Authorization ***Date/Time***

*******THE FOLLOWING SECTION MUST BE COMPLETED WHENEVER PATIENT IS UNABLE TO PERSONALLY SIGN OR AUTHORIZE RELEASE*** *OF THEIR PROTECTED HEALTH INFORMATION (PHI).*

Patient is unable to authorize release of pharmacy records/information as a result of the following **(check one):**

☐ Patient is a minor**,** ☐ Patient is mentally incompetent, ☐ Patient has a physical disability that prohibits signing, or

☐ Deceased/Other (clearly state reason if other)_____

NOTE: If the patient is deceased, only the executor and/or administrator of the estate or next-of-kin may authorize release of copies of protected health information (PHI). Therefore, documentation reflecting such individuals' legal authority to sign for release of documents must be provided.