DRUGSOURCE, INC.

AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS

I, ________________________________ who resides at ___________________________

In the city of ______________________ in the state of _____________ hereby authorize:

Mail to: **DrugSource, Inc.**
P.O. Box 1366
Elk Grove Village, IL 60009

to disclose the following specific health information by ☐ mail or ☐ fax or ☐ e-mail to:

Name: ____
(Physician, Hospital, Clinic, or other Healthcare Provider, Healthplan, Third Party Admin, Other Payer or Other Party)

Address: ____

City, St., Zip: ____

From the Health or Prescription Drug Records of:

Name: ____
(Name of Individual Whose Health or Prescription Drug Record is Being Disclosed)

Address: ____

City, St., Zip: ____

For the purpose of: ____

My authorization extends only to those data elements/documents initialed below:

_________ Statements of charges or payments
_________ Record of all prescriptions filled including name of medication and amount paid
_________ Record of all pharmaceuticals dispensed
_________ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc)
_________ Consultation Reports
_________ All of the above
_________ Other (Must be specific) ____
____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below.
4. DrugSource, Inc., its employees, officers, and pharmacists are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

______________________________ ____________________
Patient's Name Printed | Date

______________________________ ____________________
Patient's Signature (Or Guardian, If a Minor) | Expiration Date (If Other Than 1 Year From Date Above)

____
Social Security Number (For Identification Purposes Only)

______________________________ ____________________
Witness | Date