DRUGSOURCE, INC.

REVOCATION OF AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS

I, _____ who resides at _____

In the city of _____ in the state of _____ hereby revoke authorization to:

DrugSource, Inc.

P.O. Box 1366

Elk Grove Village, IL 60009

to disclose information from the protected health records of:

Name: _____
(Patient)

Address: _____

City, St., Zip: _____

My revocation extends 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 revocation is given freely with the understanding that:

1. Disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, such as for the reporting of communicable diseases.
2. DrugSource, Inc., its employees, officers, and pharmacists are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

_____ _____
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