EMPOWER

AUTHORIZATION RELEASE FORM

Authorization for Release of Prescription Records:
Medical records are kept in strict confidence and are not released without the written authorization of the patient except as permitted or required by law. I understand that Empower Pharmacy has 30 days to respond to this request.

I authorize the following protected health information to be released from the prescription record of:

PATIENT LAST NAME: _____ EMAIL ADDRESS: _____

PATIENT FIRST NAME: _____ PHONE NUMBER: _____

DATE OF BIRTH: _____ FAX OF REQUESTOR: _____

Requested Date(s) of prescription profile:

_____

Release of Records to:

NAME / ORGANIZATION: _____

ADDRESS: _____

CITY: _____ PHONE: _____

STATE: _____ FAX: _____

ZIP CODE: _____

☐ Please call when my records are ready for pick-up at: _____ (phone number to call)

☐ Please fax my records to: _____

PATIENT AGREEMENT
I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not my health plan or my health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I release Empower Pharmacy and each of their respective subsidiaries, affiliated companies, directors, officers, employers, employees, attorneys, and agents from all legal responsibility and/or liability that may arise from the release of the records I have specified. I understand that I may revoke this authorization in writing at any time, except to the extent of action has already been taken with reliance on it. I authorize Empower Pharmacy to use or disclose protected health information as described above.

This authorization will expire one (1) year from the date of signature or unless otherwise specified: EXPIRE DATE: _____

_____ DATE: _____

SIGNATURE OF PATIENT (OR OF LEGAL REPRESENTATIVE) *Sign here or Click e-sign in menu bar*

***If this form is completed by a patient or guardian, a copy of your PHOTO ID is required.**
****Please email completed form along with a copy of your PHOTO ID to info@empowerpharmacy.com**