ProCare Rx

Patient Authorization to Disclose Protected Health Information (PHI)

A. Patient Information

Patient Name:	Date of Birth:	Last Four (4) Digits of SS #:	
Address:	City:	State:	Zip:
Telephone #:	Email:		

B. Release Information

I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency, or individual named for the purpose listed in Section III.

Section I: Facility/Agency *PROVIDING* information:

ProCare Rx
1267 Professional Parkway
Gainesville, GA 30507
Phone: 800-699-3542 / Fax: 678-281-7586

Section II: Facility/Agency/Individual to whom information is to be *RELEASED*:

Name:		Fax Number:	
Address:	City:	State:	Zip:

Section III: Purpose of the Release

☐ Further Medical Care ☐ Insurance ☐ Disability ☐ Attorney ☐ Personal Use

☐ Other (specify) _____

Section IV: Protected Health Information that may be released:

☐ Prescription Information from / / to / /

Please provide a copy of record(s) to Facility/Agency/Individual at the address shown above in Section II.

- I certify that this request is made voluntarily. I understand that authorizing disclosure of my health information is voluntary. I understand that I may refuse to sign this authorization form, in which case this information shall not be released.
- I have the right to withdraw permission. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing to ProCare Rx at the address shown in Section I and will not affect information that has already been used or disclosed.
- The withdrawal will be valid as soon as ProCare Rx receives my request, but will not apply to information that has already been shared after I signed this consent form
- I know that my information may be shared more than once by the facilities/individuals in Sections I and II. Such information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, it may still be protected by other State and Federal laws.
- This authorization will automatically expire upon satisfaction of the disclosure of information, but in any event will expire 90 days from the date this consent is received, unless a different date is specified here:
- A copy of this consent form will be as good as the original, I have the right to receive a copy of authorization.

Signature: *Patient (or if not Patient, Parent or Legal Guardian)*	**Date:**

Printed Name:

If signed by a personal representative (Parent or Legal Guardian), complete the following:

Name of Personal Representative:	Relationship to Patient:

IDENTIFICATION VERIFICATION COPY ATTACHED: *(only one type of patient verification is required)*

Copy of Patient's Identification Attached Type: _____

☐ Patient's Driver's License ☐ Health or Benefits ID Card ☐ Managed Care Card ☐ Medicare Card ☐ Passport ☐ Birth Certificate

☐ Other Appropriate ID: _____ *(May be declined if not valid.)*

OFFICE USE ONLY:

Number of pages released:	Completion Date:	Delivery Method:

ProCare Rx
PBM/PHC Call Center
1267 Professional Parkway
Gainesville, GA 30507
Ph: 800-699-3542 / Fax: 844-798-8087