17250 N Hartford Dr, Suite 115
Scottsdale AZ 85255
Telephone: 1-844-436-7928

HIPAA AUTHORIZATION FORM FOR PATIENT PRESCRIPTION RECORD

1. PATIENT REQUESTING DISCLOSURE

Name:

Address:

Date of Birth:

I hereby authorize GenRX to disclose my Patient Prescription Record (PPR) reflecting information regarding my pharmacy services as set forth below:

2. AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

My Patient Prescription Record may be disclosed to the following person(s):

Name:

Address:

3. DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information that may be disclosed is my Patient Prescription Record (PPR), specifically for the periods:

All past, present, and future periods of healthcare information may be shared.

Healthcare information only from a specific period of time:

from / / to / /

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4. PURPOSE OF THE USE OR DISCLOSURE

The purpose of this use or disclosure is:

5. VALIDITY OF AUTHORIZATION FORM

This authorization will expire six (6) months from the dated signature on this Authorization Form unless indicated here:

6. ACKNOWLEDGMENT

I understand that I am signing this Authorization Form of my own free will and that my authorization will not affect my ability to obtain treatment from GenRx. I hereby state that this disclosure is at my request. A photocopy or facsimile of this signed authorization is as valid as the original and will be accepted.

I understand that if the person or entity that receives my PPR is not required to comply with the federal privacy regulations, the information described above may be re-disclosed and would not longer be protected by those regulations.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time, to the Privacy Officer, GenRx, 17250 North Hartford Dr, Suite 115 Scottsdale, Arizona 85255.

I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Signed: ______________________ (Signature of Patient or Personal Representative*)

Date:

*If the patient's personal representative, explain your authority to act on behalf of the patient: