GenRx Pharmacy
17250 N Hartford Dr, Ste 115
Scottsdale, AZ 85255

GENRX AUTHORIZATION FORM

Patient Requesting Disclosure

Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Date of Birth: ______________________________

I authorize GenRx Pharmacy to disclose my Patient Prescription Record reflecting information regarding my pharmacy services delivered by any and all GenRx Pharmacy and affiliate locations. The terms of my authorization are set forth below:

1) I authorize the information to be delivered to the following person(s).

   Name: ______________________________

   Address: ______________________________

   City/State/Zip: ______________________________

   Fax: ______________________________

   Secure Email: ______________________________
   (For requests to be sent via secure email, GenRx field staff shall forward the request to GenRx Privacy Office for secure email transmission.)

   Please deliver via:
   ☐ US Mail
   ☐ Fax
   ☐ Secure Email

2) I understand that I may revoke this authorization at any time by writing to GenRx Pharmacy Privacy Office, 17250 N Hartford Dr, Ste 115, Scottsdale, AZ 85255 for fax to 602-357-4911.
3) I understand that I am signing this Authorization of my own free will and that this authorization will not affect my ability to obtain treatment from the Pharmacy. I hereby state that this disclosure is at my request. A photocopy or fax of this signed authorization is as valid as the original and will be accepted.
4) I understand that if the person or entity that receives by prescription record may not be required to comply with the federal privacy regulations.
5) This authorization will expire in 6 months unless otherwise indicated here. If applicable, ______________________________ (enter date beyond 6 month default).

______________________________ ______________
Signature of Patient or Personal Representative Date

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Printed Name

If personal representative, please explain your authority to act on behalf of the patient:

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