Pequot Health Care

HIPAA AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Patient Name:____ **Date of Birth**: __________________

Primary Cardholders SS#:_____________________ **Card Member ID# (alternate ID):** _______________

I,____hereby authorize Pequot Health Care (PHC),
(Print patient name)
including Pequot Pharmaceutical Network and Pequot Plus Health Benefit Services, to release my pharmacy and/or medical records and information to:

Name of Recipient: ____

Address: ____

(to which it should be mailed) ____

The information to be used/disclosed consists of (Please include time period of requested information)

Note: This description must be specific and meaningful.

The information will be used/disclosed for the following purposes:

This authorization for is for valid until authorization expiration below. Unless otherwise specified in writing, information may be disclosed in electronic, hard copy, or other form.

I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by the federal or tribal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation to the addresses listed below, exceptto the extent that action has been taken in reliance on this authorization.

The authorization expires:_____________________________[insert applicable date or event]. If responding with a date, please allow PHC adequate time (at least 15 days) to process this request and provide a response.

Signature of Patient/Client:_____________________________ Date:_______________________

This form may be signed by an authorized representative or parent/guardian (if patient is a minor). Please specify relationship to patient/client, and if signing as an authorized representative, describe authority to act on behalf of the patient: _____________
____

Please submit form by: Dropping off in person at the Main Pharmacy or PHC office, email to [FILL IN], or mail to 1 Annie George Drive, Bldg. 1, Mashantucket, CT 06338

PHI disclosed to:____________________________________ID verified:_____________PHI disclosed by: _____________

COMPLETION OF ALL HIGHLIGHTED AREAS IS REQUIRED