

The Apothecary Shops

HIPAA AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE APOTHECARY SHOPS TO RELEASE MY PROTECTED HEALTH INFORMATION (PHI) FOR USE AND/OR DISCLOSURE, PURSUANT TO THE DETAILS OF THIS AUTHORIZATION, LISTED BELOW.

1. PHI TO BE DISCLOSED: _____

2. ENTITIES AUTHORIZED TO RECEIVE THIS PHI: _____

3. I may amend or revoke this authorization at any time by submitting written instructions to The Apothecary Shops. I understand that all communication must be in writing to be enforceable.

4. I understand that refusal to sign this authorization will not interfere with my capacity to obtain services from The Apothecary Shops, however, I understand that the requested PHI may not be released without this written authorization.

5. I understand that entities receiving this PHI may not be subject to compliance with HIPAA privacy standards, and therefore, I assume the risk that my PHI would no longer be protected by such regulations and may be re-disclosed by these non-compliant parties. I also understand that deliver of PHI by any other method than in person potentially endangers my PHI and/or myself. Realizing the risk, I wish to allow this information to be delivered by :

____ U.S. Mail ____ Fax () ____ - ____ ____ Other _____

6. The Apothecary Shop has the right to be compensated for providing this information, pursuant to the Notice of Privacy Practices.

7. This authorization expires one year from the date it is signed.



Signature

Date

Name (Please Print)

Relationship

23620 N. 20th Dr. Ste.12 • Phoenix, AZ 85085-0621

theapothecaryshop.com