New Customer Authorization for Release of Information (HIPAA)

Name:____ **DOB:** _____________________

Address: ____**Medical Record Number:**__________________

City: ____ **State:** _________________ **Zip code:** _____________

I authorize the use of or sharing of my personal health information as described below:

This authorization covers all personal health information on file with IV Solutions Rx Pharmacy, including both medical and billing information. All employees of IV Solutions Rx Pharmacy have authority to share this information as described below. This authorization will expire when IV Solutions Rx Pharmacy no longer retains any of my health information on file according to the applicable law.

DISCLOSURE OF INFORMATION TO SOFTWARE VENDORS TO CORRECT PROBLEMS WITH DATA: This authorization allows IV Solutions Rx Pharmacy to work with other customer software vendors, to troubleshoot problems that may arise with my electronic health records within IV Solutions Rx Pharmacy's software system. Federal Law prohibits the software vendor from giving your protected information to anyone else. Only the minimum necessary information will be disclosed as required to fix the problem.

DISCLOSURE OF INFORMATION TO ACCREDITING ORGANIZATIONS: This authorization allows IV Solutions Rx Pharmacy to share your protected health information to the employees of the accrediting agency. Federal Law prohibits employees of the accrediting agency from giving your protected health information to anyone.

DISCLOSURE OF INFORMATION TO COLLECTION AGENCIES: If your account with IV Solutions Rx Pharmacy becomes past due, IV Solutions Rx Pharmacy may share your protected health information with employees of the agency that assists with collecting payments. Federal Law prohibits employees of the collection agency from giving your protected health information to anyone. Only customers who have past due account balances will have their health information released, and only the minimum necessary information will be shared as required for the billing process.

If you refuse to sign this request, IV Solutions Rx Pharmacy may not retaliate against you in any way. If you give us the right to use your medical information by this written request, you may change your mind at any time by sending a written statement. If you do cancel this written request, IV Solutions Rx Pharmacy will no longer use your health information for the reasons covered in your request and understand that IV Solutions Rx Pharmacy cannot revoke any information that has already been shared and that we are required to keep records of the care provided. Refer to the Notice of Privacy Practices for more information regarding your rights.

Patient Signature: ____ Date: ______________________________

**Patient Representative Signature: ____

**Patient Representative Printed Name: ____

**Relationship to Patient: ____

** *If you are the patient's representative, please provide documentation or explanation of your authority to act on the behalf of the customer/patient (spouse, medical power of attorney, etc.). Without proper documentation we may not be able to process your request if your authority to act on behalf of the customer/patient is not clear.*

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