TWIN CITY PHARMACY AND SURGICAL

1708 PARK AVENUE SOUTH PLAINFIELD NJ 07080

PHONE (908) 755 7696   FAX (908) 755 6003

Email Requests to twincityrx@aol.com

AUTHORIZATION FOR HEALTH INFORMATION

Patient Information (Individual whose information is to be released):

Name: ____ Date of Birth: __________________

Address ____ City: __________________ Zip Code: ___________

Recipient Information (if different from above):

I hereby authorize **TWIN CITY PHARMACY AND SURGICAL** to release my prescription records to the following

Recipient: ____

Address (if different from above): ____

Email (if you would like your information sent via email): ____

Date range of information provided: ____

This request is for the purpose of: ____

I understand I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above mentioned facility authorized to make this disclosure. I understand that the revocation does not apply to the information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six months or on the following date: _____________________

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics. IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL. DO NOT RELEASE __________

____ ____

Signature of Patient or Authorized Representative | Date

____ ____

Description of Representatives Authority (witness signature required) | Signature of Witness