University of Toledo OP Pharmacy
CONSENT FOR RELEASE OF HIPAA PROTECTED INFORMATION

I (Patient name) _____ (DOB) _____

Hereby authorize The University of Toledo Outpatient Pharmacy to release the following information from my health

records to _____, DOB: _____
(Name of designee)

_____, _____
(Designee address) (Designee phone number)

Information to be released: ___ copy of complete pharmacy record from date _____ to date _____ or entire year _____.

Purpose of Disclosure: _____

I understand that this consent can be revoked at any time except to the extent that action has already been taken in reliance on this consent. I will be given a copy of this consent.

This consent expires in 30 days. Any future requests for release of information utilizing this consent must be accompanied by a copy of this consent.

I hereby waive and release the facility, its employees and officers and attending physicians from legal liability from the release of the above information in accordance with this authorization.

Failure to complete this form in its entirety will result in denial for release of information.

This form can ONLY be completed by the patient, or in case of a minor, the legal custodial representative. Written proof of this relationship may be requested by the pharmacy department prior to the release of information.

Signed: _____
(Patient or Legal Representative)

_____ _____
(Witness) (Relationship to patient)

_____ _____
(Date of signature - witness) (Date of signature – Patient)

Submitted 07/01/09 CSP