# Guardian Pharmacy Minnesota

**<u>Authorization for Use or Disclosure</u> of Protected Health Information**

Name of Patient: ______________________________________________________________

Social Security Number: ________________________________ Date Of Birth: ____________________

I hereby authorize the use and disclosure of my health information as indicated below. I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

I hereby authorize the release of the information checked and/or listed below for the time period beginning on Date signed and ending on One year from signed date:

[ ] Complete health care record(s)
[X] Prescription Records
[X] Consultant Pharmacist Reports
[ ] Progress Notes
[ ] Billing Statements
[X] Care Plans
[X] Other: admission and discharge plans
[ ] Other: ______________________________________________

The information checked and/or listed above is to be exchanged with: Refractions LLC. IRTS & Guardian Pharmacy
for the following purpose(s): Continuation of care & care collaboration
______________________________________________.

I understand that the individual, organization, or entity receiving my health information may provide financial or in-kind compensation to the [pharmacy/pharmacist] in exchange for the use of the disclosed information described above.

Unless otherwise revoked by me, I understand that this authorization will expire on One year from signed date or upon the completion of the use of the information for the purpose it was intended, whichever is earlier.

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 prescription drugs, payment or eligibility for benefits, unless my treatment or prescription drugs are part of a research study and the authorization would enable the above-identified information to be used for such research.

I understand that I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services.

I hereby release the above-named entity, its employees, officers, and health care professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I may revoke this request at any time by providing the above-named entity with my written notice of such revocation.

Date: ________________________ Signature of Patient: ____________________________________

Printed Name of Patient: ____________________________________

Date: ________________________ Signature of Representative: ____________________________________

Printed Name of Representative: ____________________________________

Relationship to Patient: ____________________________________

A copy of this record must be provided to the person making the request and a copy must be filed in the medical record.