# G-1 Authorization to Use or Disclose PHI

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|---|---|
| **Name of Person Making Authorization** | **Patient Address** |
| **Patient Name** | |
| **Patient Date of Birth** | **Telephone Number** |

I authorize the use and/or disclosure of my Protected Health Information ("PHI") as described below:

1. Only the following PHI may be used/disclosed pursuant to this Authorization:

_____

_____

2. Only the following person(s) or classes of persons are authorized to use/disclose my PHI pursuant to this Authorization:

_____

_____

3. Only the following person(s) or classes of persons are authorized to receive my PHI pursuant to this Authorization:

_____

_____

4. My PHI will be used/disclosed only for the following purposes **[list and describe <u>each</u> purpose]**:

_____

_____

5. I understand that I may revoke this Authorization in writing at any time by sending a letter to the Privacy Officer, ***Krista Barry***, or completing the Pharmacy's Revocation of Authorization to Disclose PHI for Marketing Purposes Form and sending it to ***PharmaCare, 3 Commerce Drive, Cumberland, MD 21502***, except to the extent that the Pharmacy has taken action in reliance on this Authorization.

6. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from the Pharmacy.

7. I understand that if the person or entity that receives my PHI is not required to comply with the federal privacy regulations, the information described above may be disclosed and would no longer be protected by those regulations.

8. This Authorization expires _____.

I hereby represent and warrant to the Pharmacy that I have the full right and legal authority to sign this Authorization on behalf of the patient named above to permit the Pharmacy and its marketing associates to use the PHI for the marketing purposes described above. I hereby represent and warrant to the Pharmacy that I am authorizing the Pharmacy and its marketing associates identified above to use the PHI for the marketing purposes described in this Authorization. If I am not the Patient, I have the full right and legal authority to make such request.

_____ _____

Patient Signature Date