HIPAA Release Form

I hereby authorize ALPS Pharmacy and their employees, agents and contractors (collectively "**ALPS Pharmacy**"), to use or disclose, as specified in this Authorization, my "**protected health information**" **(PHI)** that is covered under privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA Privacy Rule**"). I understand that "protected health information" includes records disclosed to ALPS Pharmacy by health care providers and facilities that previously provided treatment to the Patient. I also understand that "protected health information" may include information and records protected under Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as mental health treatment or related communications, or information relating to testing or treatment for AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)). I specifically request and authorize release of information in my records regarding HIV and/or AIDS, if such information is contained in my records.

Information to be Used or Disclosed:

- ☐ Complete records, including all prescriptions and billing records
- ☐ The following selected items (Please Specify): _____

Person(s) Authorized to Make the Use or Disclosure:

The following persons or class of persons are authorized to make the specified disclosures of my protected health information:

- ☐ All ALPS Pharmacy staff, including pharmacists, technicians, navigators, and clinical staff
- ☐ Only the following persons (Please Specify): _____

Recipient(s) of Use or Disclosure:

My protected health information may be disclosed to the following persons or class of persons:

Name:	**Relationship:**

Purpose(s) of the Disclosures:

- ☐ Inability or unavailability to respond to ALPS-specific questions and services
- ☐ I am requesting the disclosure of my PHI pursuant to this Authorization, and the information will be used and disclosed at my request.
- ☐ Other (Please Specify): _____

Expiration

This Authorization will expire on the following date or event _____.

Revocation

I understand that I may revoke this Authorization by submitting a written revocation to the Pharmacy Manager of the ALPS Pharmacy location which serves me, provided that such revocation shall not be effective with respect to any use or disclosure made by ALPS Pharmacy in reliance on this Authorization prior to the date of ALPS Pharmacy's receipt of my revocation.

I understand that ALPS Pharmacy cannot require me to sign this Authorization in order receive treatment unless the provision of health care by ALPS Pharmacy is solely for the purpose of creating protected health information for disclosure to a third party or for research-related treatment, in which situations ALPS Pharmacy will not provide the service unless I sign this Authorization.

I understand that the information used or disclosed by ALPS Pharmacy pursuant to this Authorization may be subject to redisclosure by the recipient in which case it might no longer be protected under the HIPAA Privacy Rule. However, I understand that in some cases, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I authorize ALPS Pharmacy to copy this Authorization and to send the recipient the re-disclosure notice required under the Federal Substance Abuse Confidentiality Requirements, whether or not my records contain information protected by those laws.

Applicable if Authorization is Requested by ALPS Pharmacy

I understand that if this Authorization is being requested by ALPS Pharmacy, ALPS Pharmacy must provide me with a copy of the Signed Authorization.

I have read and understood this Authorization and my questions have been answered. I certify that I am the Patient listed above or a person authorized to permit release of records on Patient's behalf. I hereby release ALPS Pharmacy (as defined above) from any liability arising in connection with the use or disclosure of my protected health information pursuant to this Authorization.

Patient Name(Print):_____

Patient Signature:_____Date:_____