HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE ALLURE SPECIALTY PHARMACY TO USE OR DISCLOSE MY PROTECTED HEALTH INFORMATION (PHI), PURSUANT TO THE DETAILS OF THIS AUTHORIZATION.

1. **INDIVIDUAL INFORMATION:** Name _____ Birth Date_____

_____

Street Address City State Zip

2. **INFORMATION TO BE DISCLOSED: ____ Prescriptions Records/History**

If requesting specific dates, enter here: For the following date(s) _____through_____

I understand that disclosure may include information regarding my mental health, alcohol or drug abuse treatment, HIV, other communicable diseases, and developmental disabilities, as well as genetic information, unless I list any exclusion here:

_____

3. **PERSONS AUTHORIZED TO RECEIVE THIS INFORMATION:**

1._____

Name of Recipient Address

2._____

Name of Recipient Address

4. **PURPOSE:** ___ Individual's Request ___ Other (explain here): _____

5. **DELIVERY METHOD OF PROTECTED HEALTH INFORMATION:**

I request that my PHI be sent as follows (check one): ___ Mail ___ Fax ___ E-mail

□ Fax Number_____ □ Email _____

Please note that Allure Specialty Pharmacy has an obligation to send your information securely and while we will attempt to honor your request, we will use an alternative delivery method if we question the security method you have selected.

6. **REVOCATION:** I understand that I have the right to revoke this authorization, except to the extent that Allure Specialty Pharmacy has already used or disclosed my information in reliance of this authorization. To revoke my authorization, I understand that I must send a written request for revocation to Allure Specialty Pharmacy at the address below.

7. **VOLUNTARY AUTHORIZATION:** I understand that refusal to sign this authorization will not interfere with my ability to obtain treatment from Allure Specialty Pharmacy; however, I understand that Allure Specialty Pharmacy may not be able to release the requested PHI without this written authorization.

8. **RE-DISCLOSURE AND RISK:** I understand that if my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by a person who receives my information. I understand that this re-disclosure may not be protected by HIPAA or other privacy laws.

9. **EXPIRATION:** This authorization will remain in effect for one year or the following expiration date or event here, whichever is earlier: _____

10. **COPY:** I understand that if I agree to sign this authorization, which I am not required to do, I may request a copy of the signed form.

Signature of Individual:_____ **Date:**_____

Signature of Legal Representative:_____ **Date:**_____

If signed by the Individual's Legal Representative, check all that apply:

1. The Individual is: □ a minor □ legally incompetent or incapacitated □ deceased
2. Legal authority: □ parent □ legal guardian □ next of kin/executor □ Power of Attorney(POA) for health care

MAILING ADDRESS: **ALLURE SPECIALTY PHARMACY** **ATTN: COMPLIANCE DPT - HIPAA FORMS** **4377 BRONX BLVD, BRONX, NY 10466**	**T: 866-293-1559** **F: 888-828-6230** **W**:www.allurespecialty.com **E**: info@allurespecialty.com