

RED CROSS PHARMACY, INC.

AUTHORIZATION FORM

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 class or persons are authorized to use/disclose my PHI pursuant to this Authorization:* _____

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

4. *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 re-disclosed and would no longer be protected by these regulations.*

5. *I understand that I may revoke this Authorization in writing at any time by sending a letter to [OR completing RED CROSS PHARMACY, INC.'s Authorization Revocation Form and sending it to] _____, except to the extent that RED CROSS PHARMACY, INC. has taken action in reliance on this authorization.*

6. *This Authorization expires* _____

If RED CROSS PHARMACY, INC. is requesting the Authorization for its own purposes, the following information must also be included:

7. *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 RED CROSS PHARMACY, INC..*

8. *My PHI will be used/disclosed only for the following purposes (list and describe each purpose):*

9. *I understand that I may inspect or copy my PHI that is to be used or disclosed pursuant to this Authorization (as provided for in 45 C.F.R. § 164.524).*

10. *I understand that RED CROSS PHARMACY, INC. will receive compensation for using/disclosing my PHI pursuant to this Authorization.*

Signature of Customer or Representative and Date

Customer's Name

Personal Representative's Name

Relationship to Customer