Pharmacy Practice Associates, PA, 4095 State Rd 7, Suite L-208, Wellington, FL. 33449
Tel: (561)601-5002 Web: www.medicationmaven.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR MEDICATION REVIEW

Patient Name: _____ Date:_____
Date of Birth: _____ SS #: _____
Address: _____

I, the undersigned, do hereby authorize the above-named pharmacy practice to obtain from my physicians (or their practices): _____
the following information from my clinical record:
_____
_____

By signing below, I give the above-named pharmacy practice permission to contact my physician(s), if necessary, about medication-related concerns that may be discovered in the course of the review.

I understand that this information will be used for the purpose of:
(_) Providing information to allow Medication Therapy Reviews to be provided to the patient
(_) Providing information to the physician regarding the care provided by the pharmacist
(_) Supporting the payment of an insurance claim
(_) Other: _____

I understand the following:

1. This consent will be valid until it is revoked upon written notice.
2. I may revoke this notice at any time upon written notice.
3. Any release which has been made prior to my revocation which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.
4. I may review a copy of my health profile and medication-related recommendations by contacting the above-named pharmacy practice.

I understand that every effort will be made to maintain the confidential nature of my private health information. Information about this review will not be shared with anyone except my physician and my legal representative without my written consent. I have received this pharmacy practice's HIPAA notice.

Signature of Patient/Legal Representative	Date
Print Patient Name	Source