HIPAA - Release protected health records (authorization or revocation).

The purpose of this form is to authorize the release of your protected records or to revoke that authorization. By signing this form you authorize and grant MedImpact Healthcare Systems, Inc., permission to provide my protected health records or to revoke a previous authorization to the named party.

Member Name _____ Social Security Number _____

Address _____

City, State, Zip _____

Phone _____ Email _____

I hereby *(Check one)* ☐ **Authorize** the Release of Protected Health Records **OR** ☐ **Revoke** a previous Release Authorization

This decision will be effective *(Check one)* ☐ **Indefinitely** *(no expiration)* **OR** ☐ **One year from the date executed**

For the purpose of *(describe why the records are or were requested)*

_____

The following specific health information *(Check all that apply)*

- ☐ Statements of charges or payments
- ☐ Record of all prescriptions filled including name of medication and amount paid
- ☐ Record of all pharmaceutical dispensed
- ☐ Copies of records or reports provided to the below named (i.e., hospital, lab, clinic, etc)
- ☐ Consultation Reports
- ☐ All of the above
- ☐ Other: please specify limits or specific healthcare incident

_____

From MedImpact Healthcare Systems, Inc.

To Company/Individual's Name _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Email _____

Disclosures made in good faith may have already occurred upon a previously issued authorization. Revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, such as for the reporting of communicable diseases. MedImpact Healthcare Systems, Inc., its employees, officers and pharmacists are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

Member Name _____ Date _____

Member's Signature *(or Guardian, if a minor)* _____

Witness Name *(Optional)* _____ Date _____

Please send completed form to one of the following:
Mail to: MedImpact, Attn: Customer Care, 7835 Freedom Avenue NW, North Canton, OH 44720 **Fax:** 866-250-5178
corp_web_all_form_hipaa consent_23-7496

MedImpact