PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Valley Mission Homecare Pharmacy
12509 E Mission, Suite 103
Spokane, WA 99216
509-928-6400

This Authorization, required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), authorizes us to use and disclose your Protected Health Information/Individually Identifiable Health Information (collectively referred to herein as "PHI") as described below. This authorization is effective as of the date signed by the patient and shall expire after 30 business days from that date or upon the occurrence of receipt, or when revoked, whichever occurs first. This Authorization may not be used for the purpose of marketing activities that use and disclose the patient's PHI for direct or indirect remuneration from a third party.

Section I: Patient Information (*must be completed by the* patient *or the patients Power Of Attorney* when in effect

Date Completed: _____

Patient Name (First and Last Name): _____Date of Birth _____

Section II: Detailed description of the information to be used or disclosed

a) PHI Date From: _____PHI Date To: _____

b) Description of PHI to be released (*must be specific*):

Section III: Destination of PHI

1. **PMI to be released to (*select one*)**

   ☐ **Patient only**

   ☐ **Other (*specify*) _____**

2. **Provided by (*please note that faxing, e-mail or any other form of electronic communication are not permitted*)**

   ☐ **Patient will pick up**

   ☐ **Patient representative (*insert name*) _____ will pick up**

   ☐ **Mail to (*specify address)*: _____**

Section IV: Authorization (*complete as appropriate*)

I certify that I am the patient stated above and hereby authorize Valley Mission Homecare Pharmacy to use and disclose my PHI as set forth above.

Signature_____Date _____

(*If POA*) I certify that I am the Power of Attorney for the patient stated above. I further certify that my appointment as Power of Attorney for this patient has been legally activated.

Signature_____Date _____

Important: Attach a copy of the document specifying durable Power of Attorney

Section V: Receipt

I,(name) _____certify receipt of the PHI as outlined above on (date) _____