Proprium
PHARMACY

535 Independence Parkway, Suite 400
Chesapeake, VA 23320
Phone: 757-553-3568 or 855-553-3568
Fax: 757-819-7827

HIPAA PRIVACY AUTHORIZATION FORM

**Authorization for Use or Disclosure of Protected Health Information
Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164**

***** FULFILLMENT STAFF *****
PLACE
HIPAA FORM RX LABEL
HERE

FOR PROPRIUM USE ONLY

Date Received Back: _____

Scanned In By: _____

V:100217

HIMROI

Authorization

I, _____, authorize ***PROPRIUM PHARMACY*** to disclose my protected health information to the following individual:

_____ _____
Name *Relationship to Patient*

For the purposes of discussing and authorizing pharmaceutical care, billing or claims payment, or other purposes as I may direct. Other purpose: _____

Effective Period

This authorization is for the release of medical information and covers the period of healthcare for all past, present and future periods. This authorization shall be in force and effect until revoked in writing or upon the following _____ (*date or event*), at which time this authorization will expire.

Extent of Authorization

Unless marked as an exception below, I authorize the release of my <u>*complete*</u> health record to the authorized individual named above. ***Please place an "x" next to the health record portion you <u>DO NOT</u> authorize us to discuss with this individual:***

☐ Mental Health
☐ Communicable Diseases including HIV/AIDS
☐ Treatment of Alcohol or Drug Abuse
☐ Other: _____

I understand I have the right to revoke this authorization at any time by providing a written notice of revocation. (Please contact Proprium Pharmacy at (855)553-3568 or Proprium@sentara.com for further direction.) I understand a revocation is not effective to the extent that any person or entity has already acted in reliance of my authorization, or if my authorization is obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim.
I understand my treatment, payment, enrollment, or elegibility for benefits will not be conditioned on whether or not I sign this authorization.
I also understand information used or disclosed pursuant to this authorization may be disclosed to the recipient and may no longer be protected by federal or state law.

Printed Name	*Relationship to Patient if Authorized Agent*
Signature	*Date*