



Acadiana Prescription Shop
NCPDP: 1902875
454 Heymann Blvd.
Lafayette, LA 70503
01-29-2014

2014

PAAS National® Health Care FWAC/HIPAA Policy & Procedure Manual

Request to Access or Release Protected Health Information

Patient Name: _____ Date of Birth: ___/___/_____

Address: _____

Release PHI To:

Self: Pick up Review on site Mail (address above) Email: _____

Picked up by the following authorized individual: _____

Send to: Name of Recipient: _____

Address and/or Fax: _____

Dates of PHI to Release: ___/___/_____ through ___/___/_____

PHI Requested:

Prescription Fill History (specify Rx#, drug, condition or all): _____

Billing Records (specify Rx#, drug, condition, or all): _____

Other Records (specify which records or record types): _____

Reason for the Request:

Medical Care Legal Action/Investigation Insurance Payment/Eligibility/Benefits

Taxes Personal Other: _____

Expiration of Request: This authorization shall remain in effect until:

Date: ___/___/_____ Once One (1) Year Other Event: _____

I acknowledge that I have the right to inspect and receive a copy of the health information I have authorized to be used or disclosed by this form. I understand that Acadiana Prescription Shop **may charge a fee for the costs of copying, mailing or other supplies** to respond to this request. I also acknowledge that I may modify or terminate this authorization in writing at any time. I understand that any modification or termination will not apply to uses or disclosures that have already occurred based on prior authorization or any use or disclosure that is required or permitted by law. I further acknowledge that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy law.

Signature of Patient or Personal Representative

___/___/_____
Date

Personal Representative (Print)

Relationship to Patient