Main Line Health | BEHAVIORAL HEALTH

Pharmacy Release Form

I, _____, HEREBY FREELY AUTHORIZE
(Name)

MAIN LINE BEHAVIORAL HEALTH AFFILIATES
(Person or Facility Releasing Information)

TO RELEASE TO:

Pharmacy Name: _____

Pharmacy Phone: _____

- My presence in treatment __X__
- My projected prognosis _____
- The nature of the program __X__
- Diagnosis Code __X__
- Medications being prescribed to me __X__

The Purpose of this information is for/to one or more of the following:

- Continuity of Care __X__
- Update medical records __X__
- Settle Insurance claim _____
- Authorization of treatment _____

The method of releasing this information is:

- Telephone Contact __X__
- Fax __X__
- Mail __X__
- Email __X__

THIS AUTHORIZATION IS SUBJECT TO VERBAL OR WRITTEN REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. THIS AUTHORIZATION WILL EXPIRE 360 DAYS AFTER THE DATE OF MY SIGNATURE OR ON _____. THIS RELEASE IS VALID FOR THE FULL 360 DAYS, EVEN IF TREATMENT IS COMPLETED AND/OR TERMINATED. THIS RELEASE OF INFORMATION IS LIMITED TO THE PERSON OR ORGANIZATION NAMED ABOVE AND WILL NOT BE USED FOR ANY OTHER PURPOSE THAN THAT STATED.

_____ _____

Witness's Signature Date Patient's Signature Date

CIRCLE ONE: PATIENT DOES / DOES NOT WISH COPY OF THIS CONSENT

"THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42CRF, PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE."