RELEASE OF INFORMATION/RIGHT TO PRIVACY
HIPAA PATIENT CONSENT FORM

TO OUR PATIENTS: Before you receive pharmacy services from Rx4Prevention, the law requires that we explain your rights and responsibilities while a patient at Rx4Prevention. If you have a complaint or concern about your care, please discuss it first with your care provider. If your concern remains unresolved, you may call the pharmacy at the main number and ask to speak with the Manager. Please read and sign the form below. Ask questions if you do not understand it.

ONSENT FOR TREATMENT: By signing this form, I consent to and authorize my health care provider to examine and treat me today. I understand that this could include vaccinations, administration fees, or other medication. I understand that my provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment.

RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW:
I understand that it is important that my medical providers have access to any of my medical records which will help them to safely treat me and manage my medical care. I agree that a copy of my medical records, may be sent to any of my physicians or healthcare providers. This includes release to any hospital in which Rx4Prevention may be contacted for purposes of medical care and for business operations relating to my health. I also agree that Rx4Prevention can release my medical records to accrediting or regulatory agencies if those agencies request my records and if the law allows those agencies access to my records. (Records are not automatically sent to your referring physician. They must be requested)

INSURANCE/MEDICARE/MEDICAID ASSIGNMENT OF BENEFITS – PAYMENT OF RX4PREVENTION MEDICAL BILLS: I would like a “third party payer” (for example, my insurance company/Medicaid/Medicare or its related organizations) to pay the bills for my services at Rx4Prevention, to the extent the Payer is required to do so under my policy of insurance or the law. Therefore, I request that payment of my bills by the “third party payer” be made to Rx4Prevention on my behalf for any services furnished to me by or inRx4Prevention. I assign the benefits payable for pharmacy services to the pharmacist or organization furnishing the services. In consideration of pharmacy visits, I agree to payRx4Prevention for all charges not covered by any third party payer.

RELEASE OF MEDICAL RECORDS FOR BILLING PURPOSES: In many instances, a “third party payer” may pay a portion of my entire medical bill related to today’s visit. Examples of “third party payers” are medical and auto insurance companies, worker’s compensation insurance carriers, Medicaid, Medicare or its related organizations. In order for a “third party payer” to pay any or all of my bills related to today’s visit at Rx4Prevention, I understand the “third party payer” may require information about the medical care and treatment I received. I authorized Rx4Prevention to release to the “third party payer” any information needed to determine the payments related to the medical treatment I receive.

RELEASE OF MEDICAL RECORDS FOR MEDICAL OR SCIENTIFIC RESEARCH: Rx4Prevention may disclose, on a

completely anonymous basis, information concerning your case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulations.

PATIENT’S RIGHT TO PRIVACY: I acknowledge that I have been made aware of Rx4Prevention privacy practices which are posted in the reception area. If I would like a copy of Rx4Prevention’s privacy brochure I will be given one at my request.

I understand I have the right to revoke this consent, in writing, at any time except where Rx4Prevention has already made disclosures in reliance to this consent.

Date: ______________________________ Patient Date of Birth: _________________________________

Patient Account #: ____________________

Signature of
Patient or Other: X __________________________ Print Name: _______________________________________

If Other,
Relationship to Patient: _____________________ Reason Patient is unable to sign: ________________________