

**Authorization to Use and Disclose Health Information**

**PLEASE PRINT CLEARLY**

Patient's Name: \_\_\_\_\_ ID Number \_\_\_\_\_

Address: \_\_\_\_\_ SSN: \_\_\_\_\_  
Street \_\_\_\_\_

\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City, State, Zip MM DD YYYY

Plan Sponsor/Employer (if available) \_\_\_\_\_

I authorize CuraScript, Inc and any of its affiliated covered entities which include Lynnfield Drug, Inc., Lynnfield Compounding Center, Inc., Chesapeake Infusion, Inc., Byfield Drug, Inc., Specialty Infusion Pharmacy, Inc., CuraScript Infusion Pharmacy, Inc., and Priority Healthcare Pharmacy Inc., to use or disclose my health information as described below. I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and no longer protected by federal privacy regulations.

1. The following health information may be used or disclosed:
  - Pharmacy billing records    prescription records    history and physical
  - Consultation reports    progress notes    discharge summary    other \_\_\_\_\_
2. Covering the periods of health care: FROM (date): \_\_\_\_\_ TO (date) \_\_\_\_\_
3. The health information identified above may be used or disclosed for the following purpose(s):  
\_\_\_\_\_
4. The health information identified above may only be disclosed to the following individual(s) or organization(s):  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_
5. I understand that the health information that I authorized to be used or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health or substance abuse.

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that my refusal to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment.
7. I understand that if this authorization is for the disclosure of health information for a research study, I may refuse to sign this authorization. I understand that if I refuse to sign this authorization, I may not receive the treatment related to the research study.
8. I understand that I may revoke this authorization at any time provided that the information has not already been disclosed. Information that has already been disclosed may not be further disclosed once the authorization has been revoked. I understand that if I choose to revoke this authorization, I must do so in writing to the following address:  
  
CuraScript, Inc.  
P.O. Box 66561  
St. Louis, MO 63166-6561
9. I understand that I have a right to request and receive a copy of CuraScript Notice of Privacy Practices at [www.curascript.com](http://www.curascript.com)
10. A photocopy of this authorization is as valid as the original.
11. I understand that this authorization will expire one hundred eighty (180) days from the date signed below.

<b>SIGNATURE</b>	
_____ Signature of patient or patient's personal representative	_____ Date
_____ Printed name of patient or patient's personal representative	
If signed by patient's personal representative, please complete the following:	
Relationship to patient: _____	
Authority to act for the patient: _____	

Please allow 6-8 weeks for the request to be processed.  
Please return completed form along with a check or money order for the non-refundable processing fee of \$50.00 to:

CuraScript, Inc.  
Attn: Legal Department- Records Custodian  
One Express Way  
Mail Route HQ2E03  
St. Louis MO 63121  
866-254-2313 (fax)

If the state statute regarding the charging for healthcare records covers this request, please submit a copy of that statute and payment pursuant to that statute.  
For questions or concerns, please call toll-free 800-332-5455, x344102.