

5580 19th Ct SW Unit 2 Naples, Fl 34116 - Telephone: (239) 304-2471 Fax: (239) 3042-2741

**Medication History Authority**

Authorization for Release of Health Information

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

In accordance with Fl State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. SW Florida Regional Medical Center uses SureScripts, Inc. a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be used by SW Florida Regional Medical Center in providing me with health care services.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment and/or confidential HIV related information by SureScripts, Inc. to SW Florida Regional Medical Center.
3. I have the right to revoke this authorization at any time by writing to SW Florida Regional Medical Center. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan or eligibility to benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by state and federal law.
6. This authorization expires one year from the date of signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE SW FLORIDA REGIONAL MEDICAL CENTER TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITED UNDER APPLICABLE LAW.

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Signature or Patient or representative authorized by law Date:

* I decline signing this authorization and chose not to allow SW Florida Regional Medical Center to access SureScripts, Inc. a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy.

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Signature or Patient or representative authorized by law Date:

Last updated July 2016