Authorization to Disclose Personal Health Information

This release form authorizes the named physician, clinic, pharmacist, pharmacy or organization to release medical and financial information about me to a volunteer representative of the *Senior Health Insurance Benefits Assistance (SHIBA)* Program for the purpose of assisting me to enroll in a prescription drug benefit plan.

- I understand that I have the right to revoke this authorization at any time.
- I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the physician, clinic, pharmacist, pharmacy or organization named in this document.
- I understand that the revocation will not apply to information that was previously released in response to this authorization.

This authorization will expire **six months** from the date signed by the patient or his/her Legal Representative.

____
Signature of patient or legal representative

____
Relationship to patient

____
Date

____
Signature of SHIBA volunteer receiving health information

____
Date

Authorization to Disclose Personal Health Information

PATIENT INFORMATION

Patient name: ____________________

Phone number: ____________ DOB: ____________ SSN: ____________

OBTAIN RECORDS FROM

I request/authorize the following physician, clinic, pharmacist, pharmacy or organization to release the above-named patient's health care information.

Medical Authority/Organization: ____________________

Address: ____________ City: ____________ State: ______ Zip Code: ____________

Phone number: ____________ Fax: ____________

INFORMATION TO BE RELEASED TO

I request and authorize the above named physician, clinic, pharmacist, pharmacy or organization to release information to the Senior Health Insurance Benefits Assistance Program.

Name of volunteer: ____________________

Phone number: ____________ Fax: ____________

TYPE OF INFORMATION TO BE RELEASED

❑ All medical records ❑ All medical billing records

❑ Specific information: ____________________

❑ Other: ____________________