

**HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

I AUTHORIZE AVELLA SPECIALTY PHARMACY TO USE OR DISCLOSE MY PROTECTED HEALTH INFORMATION (PHI),  
PURSUANT TO THE DETAILS OF THIS AUTHORIZATION.

1. **INDIVIDUAL INFORMATION:** Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

2. **INFORMATION TO BE DISCLOSED:** \_\_\_ Prescriptions Records/History

If requesting specific dates, enter here: For the following date(s) \_\_\_\_\_ through \_\_\_\_\_

I understand that disclosure may include information regarding my mental health, alcohol or drug abuse treatment, HIV, other communicable diseases, and developmental disabilities, as well as genetic information, unless I list any exclusion here:

3. **PERSONS AUTHORIZED TO RECEIVE THIS INFORMATION:**

1. \_\_\_\_\_  
Name of Recipient \_\_\_\_\_ Address \_\_\_\_\_

2. \_\_\_\_\_  
Name of Recipient \_\_\_\_\_ Address \_\_\_\_\_

4. **PURPOSE:** \_\_\_ Individual's Request \_\_\_ Other (explain here): \_\_\_\_\_

5. **DELIVERY METHOD OF PROTECTED HEALTH INFORMATION:**

I request that my PHI be sent as follows (check one): \_\_\_ Mail \_\_\_ Fax \_\_\_ E-mail

Fax Number \_\_\_\_\_  Email \_\_\_\_\_

*Please note that Avella Specialty Pharmacy has an obligation to send your information securely and while we will attempt to honor your request, we will use an alternative delivery method if we question the security method you have selected.*

6. **REVOCAION:** I understand that I have the right to revoke this authorization, except to the extent that Avella Specialty Pharmacy has already used or disclosed my information in reliance of this authorization. To revoke my authorization, I understand that I must send a written request for revocation to Avella Specialty Pharmacy at the address below.

7. **VOLUNTARY AUTHORIZATION:** I understand that refusal to sign this authorization will not interfere with my ability to obtain treatment from Avella Specialty Pharmacy; however, I understand that Avella Specialty Pharmacy may not be able to release the requested PHI without this written authorization.

8. **RE-DISCLOSURE AND RISK:** I understand that if my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by a person who receives my information. I understand that this re-disclosure may not be protected by HIPAA or other privacy laws.

9. **EXPIRATION:** This authorization will remain in effect for one year or the following expiration date or event here, whichever is earlier: \_\_\_\_\_

10. **COPY:** I understand that if I agree to sign this authorization, which I am not required to do, I may request a copy of the signed form.

**Signature of Individual:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Legal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If signed by the Individual's Legal Representative, check all that apply:

1. The Individual is:  a minor  legally incompetent or incapacitated  deceased
2. Legal authority:  parent  legal guardian  next of kin/executor  Power of Attorney(POA) for health care

MAILING ADDRESS:  
AVELLA SPECIALTY PHARMACY  
ATTN: AUDIT DEPARTMENT - HIPAA FORMS  
24416 N. 19th AVE. — PHOENIX, AZ 85085

PHONE: 623-742-1709  
FAX: 623-266-0715  
Website: [www.avella.com](http://www.avella.com)  
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