

Authorization to Release Protected Health Information (“PHI”)

PHI is individually identifiable health information that could be used to identify me and relates to my physical or mental condition, provision of care for the condition or payment of such care. The PHI released may include but is not limited to, my name, address, age, date of birth, health plan ID number, social security number, patient profile prescriptions, prescription history, pharmacy claims history, and other related pharmaceutical records.

I, _____,
Your Name

Authorize Foothills Professional Pharmacy, LTD. To release my PHI to:

- Myself: _____
Your Name

- Personal Representative, Spouse, Child, Attorney, or Legal Counsel:

Name *Relationship*

Your Signature

Date

Please provide the mailing address or fax number where you authorize your PHI to be sent:

ATTN

Street Address

City, State, Zip

Fax Number

Fax this completed form to Foothills Professional Pharmacy, LTD. at 480-496-4450.