AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS

I,______________________________who resides at___________________________in the city of____________________in the state of_____________hereby authorize:

Mail to: Elixir Specialty Pharmacy
7835 Freedom Avenue N.W.
North Canton, OH 44720

To disclose the following specific health information by ☐ mail or ☐ fax or ☐ email to:

Name:____
(Physician, Hospital, Clinic, or other Healthcare Provider, Health Plan, Third Party Admin, Other Payer or Other Party)

Address:____

City, St., Zip: ____

From the Health or Prescription Drug Records of:

Name:____
(Name of Individual Whose Health or Prescription Drug Record is Being Disclosed)

Address:____

City, St., Zip:____

For the purpose of:____

My authorization extends only to those data elements/documents initialed below:

________Statements of charges or payments
________Record of all prescriptions filled including name of medication and amount paid
________Record of all pharmaceutical dispensed
________Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc)
________Consultation Reports
________All of the above
________Other (Must be specific) ____
____