REVOCATION OF AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS

I,_____who resides at _____
in the city of_____in the state of_____hereby revoke authorization to:

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

to disclose information from the protected health records of:

Name: _____
(Patient)

Address:_____

City, St., Zip: _____

My revocation extends 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 pharmaceuticals 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) _____

This revocation is given freely with the understanding that:

1. Disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, such as for the reporting of communicable diseases.
2. Drug Source, Inc., its employees, officers, and pharmacists are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

_____ _____
Patient's Name Printed Date

_____ _____
Patient's Signature (or Guardian, if a minor) Expiration Date (If 1 year from date above)

_____
Social Security Number (For Identification Purposes Only)

_____ _____
Witness Date