AUTHORIZATION
TO RELEASE PHARMACY RECORDS

Patient Name_____
Last First MI

Birthdate_____ *Under age 18 □ Yes □ No Parent/Guardian _____

Address _____

City _____ State _____ Zip _____

Home Phone_____ Cell Phone _____

Email_____@_____._____

I request and authorize the release and disclose information maintained by the pharmacy including:

- **Prescription history (2 years)**
- **Immunization records**
- **Prescriber information**
- **Other:** _____

I understand these records may contain information created by other persons or entities, including physicians and other health care providers as well as information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services (excluding psychotherapy notes), reproductive health services, and treatment for sexually transmitted diseases.

The purpose of this request is being made either at the request of the individual or the office of Your Smile.
I may revoke this authorization, at any time, by sending a written revocation to the Meijer Privacy Specialist at the address below. The revocation will not apply to records that have already been released by the pharmacy under this authorization.

I understand Your Smile will not condition treatment, payment, appointments, or eligibility for benefits on whether I sign this form.

I understand after my pharmacy releases the information identified above, the recipient could re-disclose the information and it is no longer protected by privacy laws. I understand I may receive a copy of this authorization after I sign it.

A photocopy of this authorization shall be considered valid as the original.

Patient Signature _____ Date _____

*Other Signature _____ Date _____

If signed by someone other than the patient, please indicate your authority to sign, such as the parent of a minor, *Power of Attorney, *legal guardian, *estate executor, or *personal representative. **Supporting documentation must be provided.*

Please send this form and the requested information to:

Your Smile
133 Bel Air Rd or yoursmileinfo@yahoo.com or Fax: 410-877-3000
Bel Air, MD 21014