College Pharmacy
Compounding Specialists

2/2015

Patient Contact Authorization Form

Respect for your privacy is a top priority at College Pharmacy. Concern for your privacy rights goes hand in hand with our focus on maintaining and improving your health. College Pharmacy's practices are in compliance with federal regulations that are part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which addresses your rights to privacy and handling of Protected Health Information ("PHI").

Often, we have patients request that we leave detailed voice messages about their prescription or we have patients notify us that a friend or family member will be picking-up their prescription. While we try to accommodate our customers, we also have to adhere to HIPAA regulations. The form below will allow us to leave voice messages at specific telephone numbers, authorize prescription pick-up contacts, and release information about you, the patient, to individual(s) who are non-medical in relation.

This Patient Contact Authorization does not have an expiration date. It can be changed by the patient at anytime for any reason.

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Authorization Date:_____

_____

Patient Full Name (Print) Date of Birth

Required Section #1: Voice Message Authorization

Basic: "Hello, this is Jan from College Pharmacy. I am calling about your prescription. Please contact me at your convenience." Or, "Hello, this is Jan from College Pharmacy. Your prescription is ready to be picked-up."

Detailed: On occasion, there may be a problem in processing your prescription. Or, maybe we need to provide you with additional information about your prescription. A detailed message would include more specific details about the reason for the call. Unless "Detailed" authorization is granted, we will leave a "Basic" message due to HIPAA compliance practices.

Can College Pharmacy leave voice messages at the numbers you provide below? (Please circle your choices.)

Home Phone: _____ Yes / No Detailed or Basic Message Authorized

Cell Phone: _____ Yes / No Detailed or Basic Message Authorized

Work Phone: _____ Yes / No Detailed or Basic Message Authorized

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Required Section #2: Authorized Contacts (Patient MUST Select One of the Options Below.)

Option #1: Authorized Contact & Information To Be Released

These individual(s) have been selected by the patient listed above as an authorized contact for the specified information.

1.)_____

Authorized Contact Full Name (Print) Telephone Relation

2.)_____

Authorized Contact Full Name (Print) Telephone Relation

Information to Be Released to Contacts: Patients are to select information and/or items that the above individual(s) listed can receive and are authorized to know. **Please INITIAL by all items or information that can be released to the above individual(s).**

_____ Medical Information (Any information regarding your health diagnosis and treatment plans, etc.)
_____ Financial Information (Any information regarding your insurance, payment plans, credit & balances, etc.)
_____ Prescription Pick Up (All individuals who are picking up prescriptions must show a form of identification.)
_____ Documentation Pick Up (All individuals who are picking up any documentation must show a form of identification.)

Patient Signature: _____Date_____

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Option #2: Authorizing Patient Information NOT to be Released

By signing this section below, you are choosing **NOT to release ANY of the above information to ANY individual(s) other than yourself**. This means that spouses, children, family members, etc cannot pick-up prescription(s) or access any information regarding your prescription(s) filled at College Pharmacy.

Patient Signature: _____Date_____

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