MDR Pharmaceutical Care
17071 Ventura Boulevard, Suite 126
Encino, California 91316
800. 515. DRUG (3784)
Fax: 888. 939. 2020
E-Mail: info@mdrusa.com

MDR Encino Pharmacy
17071 Ventura Boulevard, Suite 100
Encino, California 91316
800. 515. DRUG (3784)
Tel: 818. 788. 5858
Fax: 818. 788. 0607

MDR Westwood Center Pharmacy
10921 Wilshire Boulevard
Los Angeles, California 90024
Tel: 310. 208. 6666
Fax: 310. 824. 0056

AUTHORIZATION FOR RELEASE OF INFORMATION AND/OR DISCLOSURE OF MEDICAL INFORMATION

I the undersigned hereby authorize MDR Pharmaceutical Care and its related entities, to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have designated as the recipient of this information.

Please send medical information to:

_____
Name of Person or Entity to Receive Information

_____
Street Address City, State, Zip Code

Release and/ or disclose records regarding: _____
Name of Patient (Print)

_____ _____
Date of Birth Patient Address City, State, Zip Code

(_____) _____ (_____) _____
Primary Contact Phone Number Fax Number

This authorization applies to the following information to be released:

_____

_____

_____

For the purpose of: (if patient initiates authorization, they can elect not to provide a statement)

_____

_____

This authorization expires [insert date or event] or if no date is indicated, the authorization will expire twelve (12) months after the date of signing this form.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individual identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I understand that this authorization may be revoked in writing at any time and is effective upon receipt. Written revocation will not affect any action taken in reliance on this authorization before the revocation is received.
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. However, California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.
- I understand I have a right to receive a copy of this authorization.
- I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization.

I declare under penalty of perjury that the information on this form is true and correct.

Dated: _____

_____ _____

Patient Name (Print) Patient Signature

_____

Patient E-mail

Please attach a copy of identify information. This can be a copy of your driver's license, passport or any other picture ID document.

Confidential Health Information

Health care information is personal information related to a person's health care. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Redisclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you penalties described in federal and state laws.

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