



## Authorization for Use or Disclosure of Health Information

Patient Name (Please Print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

By signing below, I hereby authorize CuraScript, Inc. to use and/or disclose protected health information (PHI) related to drug prescriptions from my health records to third-party representatives who work with CuraScript to coordinate community and financial assistance options. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation to the PAH Program Manager, CuraScript Inc, 6272 Lee Vista Blvd, Orlando, FL 32822. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. This authorization will remain in effect until revoked by the patient or until the patient is no longer on service with CuraScript. I understand that treatment and/or payment is not conditioned upon the signing of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of information cannot be protected by federal confidentiality rules. I understand that the health information that I authorized to be used or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health or substance abuse. If I have questions about disclosures of my health information, I can contact the Privacy Officer at CuraScript, Inc (888-773-7376 ext. 343019). I understand that I am entitled to a copy of this authorization.

Signed by Patient: \_\_\_\_\_

Today's Date: \_\_\_\_\_

OR

Signed by Legal Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Please Fax this form to **877.305.6745** or mail to  
PAH Program Manager, CuraScript Inc,  
6272 Lee Vista Blvd, Orlando, FL 32822