Medication Coordination Pharmacy AUTHORIZATION FORM

1041 Pearl St, Brockton, MA 02301
Fax (508) 510-4398

PATIENT REQUESTING DISCLOSURE

Name: _____
Address: _____
City/State/Zip Code _____
Date of Birth _____

I hereby authorize Medication Coordination Pharmacy to disclose my Patient Prescription Record (PPR), reflecting information regarding my pharmacy services as set forth below:

1. My Patient Prescription Record (PPR), may be disclosed to the following person(s):
   Name: _____
   Address: _____
   City/State/Zip Code: _____
2. I understand that I may revoke this authorization at any time by writing to Medication Coordination Pharmacy, 1041 Pearl St, Brockton, MA 02301 or fax to (508) 510-4398, except to the extent that Medication Coordination Pharmacy has acted in reliance on this authorization.
3. I understand that I am signing this Authorization of my own free will and that this authorization will not affect my ability to obtain treatment from the Pharmacy. I hereby state that this disclosure is at my request. A photocopy or facsimile of this signed authorization is as valid as the original and will be accepted.
4. I understand that if the person or entity that receives my PPR is not required to comply with the federal privacy regulations, the information described above may be redisclosed and would no longer be protected by those regulations.
5. This authorization will expire 6 months from the dated signature on this authorization, unless otherwise indicated here _____

_____ _____
Signature of Patient or Personal Representative* Date

*To the patient's personal representative, explain your authority to act on behalf of the patient:
_____
_____
_____
_____