

**AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION**

By signing below I authorize Bellevue Drug Company and/or its authorized agents to release my dependents' and/or my own personal health information to my authorized representative or me.

**IMPORTANT:** Any individual 18 years of age or older is required to sign this document personally. A parent or legal guardian may sign on behalf of dependent children.

Please complete the following section: Date: \_\_\_\_\_

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZipCode: \_\_\_\_\_

<b>Please indicate name and relationship of individual(s) authorized to receive PHI or be contacted on your behalf:</b>	
NAME _____	RELATIONSHIP _____
ADDRESS/PHONE # _____	
<b>REPORT TYPE: (Please check one)</b>	
_____ (\$ Total Only Report (Income Taxes, etc.) - Dates Requested: _____)	
_____ Detail Report (Provides Rx Detail) – Dates Requested: _____	

**All requests will be ready for pickup within 3 business days.**  
**Please note: a processing fee will be charged for multiple requests of health records.**

Please list below the names and dates of birth for all individuals requesting prescription history or personal health information followed by the appropriate corresponding signature. *(Reminder: if patient is 18 yrs. of age or older, they are required to sign release.)*

\_\_\_\_\_  
Print Name Birth date Signature of Patient Required if over 18 yrs.

\_\_\_\_\_  
Print Name Birth date Signature of Patient Required if over 18 yrs.

\_\_\_\_\_  
Print Name Birth date Signature of Patient Required if over 18 yrs.

\_\_\_\_\_  
Print Name Birth date Signature of Patient Required if over 18 yrs.

For Office Use Only  
Date Processed \_\_\_\_\_ Completed By \_\_\_\_\_