- University of Kentucky Hospital A.B. Chandler Medical Center
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Heatlh Clinics

PHARMACY AUTHORIZATION FOR RELEASE OF INFORMATION (for Use and Disclosure)

(Patient Label Here)

Please fill out all sections or the form may be returned to you.

Patient Name: ______________________ Social Security Number: ______________

Address: ______________________ Date of Birth: ______________

City: __________ State: ______ Zip: ______ Phone Number: ______________

Type of Release ☐ **Paper Copies** ☒ **Electronic** ☐ **Permission to discuss care**

☐ **Review records at UK (must make an appointment)**

Send Information from:
☒ All UK HealthCare facilities
☐ UK College of Dentistry
☐ Other________________________________

Send Information to: Relevant Foundations, Charities, and Drug Manufacturers for Pharmacy Patient Assistance Program (PPAP) purposes only.

I would like records from the Previous 365 days.
Please check the records you would like:

☐ Records related to (specify): ______________________________
(examples: car accident or appendectomy)

☐ Discharge Summary ☐ Pathology Report(s)
☐ TB Screening ☐ Laboratory Report(s) ☐ X-Ray Report(s)
☐ Immunization Record ☐ Photo/Video/Other ☐ X-Ray Image(s)
☐ ER Notes ☐ Outpatient Notes ☐ All records
☐ Surgery Reports ☐ Psychological Test Report ☒ Other: (specify) **Personal demographic, diagnostic, therapeutic, and/or financial information required relating to applications for drug manufacturer PPAP and copay assistance**

Sharing of Special Protected Records: I authorize the sharing of information about:

a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS) ☐ YES ☐ NO / NA
b. The diagnosis or treatment of drug and/or alcohol abuse ☐ YES ☐ NO / NA
c. The treatment and/or consultation for mental health or psychiatric disorders ☐ YES ☐ NO / NA

Reason records are needed (check all that apply):

☐ For another doctor or hospital ☐ Social Security/disability ☐ Legal ☐ Personal use ☒ Other (specify) Pharmacy Patient Assistance Program.

Authorization to act as agent for enrollment:
By signing this letter, you are requesting to participate in such available pharmacy patient assistance programs, and you authorize UK HealthCare to sign any and all forms and applications pertaining to Patient Assistance Programs on your behalf.

This Authorization will expire on 365 days from signing **(1 year).**
If no date is included the Authorization will expire in 90 days.

- I understand that I may ,revoke this Authorization at any time, unless the Authorization was obtained as a condition of obtaining insurance coverage; that my revocation must be submitted in writing to the Registration Office at the Facility/location where I originally submitted/filed this authorization; and that the revocation shall be effective except to the extent that the Facility has already used or disclosed information in reliance on the Authorization.
- I further understand that treatment payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization, however, Facility may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signing this Authorization, and Facility may condition the provision of research-related treatment on my signing this Authorization.
- I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the facility, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

Date **Time**

Signature of Patient

If patient is unable to sign, secure consent of Legal Representative and indicate reason below:
☐ Minor ☐ Incompetent ☐ Deceased
Proof of designation must be filed in the chart or sent with this request.

Signature of Legal Representative and Relationship to Patient

Signature of Witness for Psychiatric Records

- University of Kentucky Hospital A.B. Chandler Medical Center
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Heatlh Clinics

PHARMACY AUTHORIZATION FOR RELEASE OF INFORMATION
(for Use and Disclosure)

(Patient Label Here)

UK HealthCare Pharmacy Patient Assistance Programs

Why should I sign this form?

At UK HealthCare, we want to keep the cost of your medicines as low as possible. One way we do this is by finding programs by drug makers that lower the cost to patients. These are called Pharmacy Patient Assistance Programs.They help patients who are not insured get the medicines they need.

There is no guarantee a program will accept you. The drug companies make that decision. On the other hand, there is no risk to you. Enrolling in these programs will not affect any other financial assistance you are seeking. If a program accepts you, you may get your medicine at no cost. Charges for your medicine will not be on your bill.

What will UK HealthCare do if I sign this form?

Drug makers with programs ask for information about you. They check the information to make sure you qualify. They may also need your signature. If you sign this form, we will look for programs and apply for you.

By signing this form, you give UK HealthCare permission to do the following:

- Provide drug makers only the information needed to apply for each program.
- Sign program application forms as your agent.

We have a duty to protect your privacy. We will only use your information to apply for medicine assistance. We will share the minimum information needed to apply.

What if I sign the form then change my mind?

You may revoke this authorization at any time. You must do this in writing at the UK HealthCare location where you filed this form. Your power to revoke may be limited if:

- You signed this form as a condition for getting insurance.
- You signed this form and UK HealthCare relied on it to use or release information.

What if I have questions or concerns?

You can call our office at 859-323-2512. We will be happy to talk with you about Pharmacy Patient Assistance Programs.