SEND FORM TO:
RPM Pharmaceutical's Clinical Pharmacist
2115 South 61st Street, Omaha, NE 68106
T: 402-765-8689| Fax: 402-513-7206 | nathan.suck@rpmpharm.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Type of Information to be Disclosed

Check applicable

☐ Office Visits, specify (Dates:_____)
☐Imaging or Labs (Dates:_____)
☐All medical information in record**
☐Immunizations
☐ Other, Specify:

_____
_____a

****Important Note**
Your medical record may include ***highly sensitive*** information (e.g. mental health records, records of drug or alcohol abuse, HIV, STDs, or other sensitive diagnoses). By selecting this option, you agree to release this information as well.

By law, RPM Pharmaceuticals (RPM) cannot release Psychotherapy notes with the same authorization form used for other medical records. If these notes are need, please use our Psychotherapy Notes Release Form.

Patient Information

I request access as the☐Patient ☐ Parent☐ Guardian, Representative, or POA *(documentation required)*

Name of Patient *(print clearly)* | SSN | Date of Birth

Address | City, State, Zip Code | Contact Phone Number

Manner of Information Requested: ***(Information Sent or Received is Remains Confidential)***

☐ Paper ☐ Fax ☐ Referral for Medication Therapy Services ☐ Transfer to Other Care Providers of Patient's Healthcare Network.

Recipient or Sender Information ***(select one side or the other)***

SEND medical information TO *(Check☐if same as the above)*	RECEIVE medical information FROM *(Only use if sending information to RPM ☐)*
Name of Person or Entity *Receiving*	Name of Person or Entity *Sending*
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Telephone and Fax, if necessary	Telephone and Fax, if necessary

By signing below I authorize RPM to release all medical information in the way that I have indicated on this form. I understand that I may revoke this authorization at any time in writing, subject to RPM Notice of Privacy Practices. I understand that I can refuse to sign this form and still receive treatment. I understand that RPM cannot guarantee the recipient will not inappropriately re-disclose this information. I agree that this authorization will expire one (1) year or end of Medication Therapy Services.

Signature of Patient or Representative | **Date** | **Name, Relationship** ***(if not the patient)***

FOR OFFICE USE ONLY
Date received: **Approved by:** **If denied, reason:**