

## Release of Information Form

MyMedSupplies  
Receiving Client  
Records

By signing below, I authorize my health care provider(s) and/or entities with information regarding my medical history and treatment to release it to MyMedSupplies.

OR

MyMedSupplies  
Sending Client  
Records

By signing below, I authorize MyMedSupplies to release and/or discuss my MyMedSupplies client records to:

Individual/Company Name:

Phone:

Individual/Company Name:

Phone:

### Purpose of Disclosure

At the request of the individual    Legal    Referral    Insurance Coverage  
Continuity of Care    Other:

All Dates of Service    OR    Date Range:    to

Entire Chart    OR    Financial Statement    OR    Other

The following items must be initialed **ONLY** if they are to be included in the use or disclosure of the above records:

Mental Health (not including psychotherapy notes)    HIV/STD Information    Drug/Alcohol Abuse

I understand that I have the right to refuse to release my medical records and that by signing this agreement I waive this right.

I also understand that if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA privacy rule. However, the recipient may be prohibited from disclosing my health information under another applicable state or federal laws and/or regulations.

This consent is valid for whatever time period is reasonably necessary for the purposes of MyMedSupplies to carry out my treatment, payment, and/or their healthcare operations and shall remain in effect until such time as I revoke it in writing. Except to the extent that action has already been taken in reliance upon this authorization, I understand that I have the right to revoke this authorization at any time by giving written notice to MyMedSupplies.

I understand that MyMedSupplies does not condition service or payment if I refuse to sign this authorization.

Client Name

Date of Birth

Signature of Client or Legal Representative

Date

Printed Name of Legal Representative

Relationship

More information regarding MyMedSupplies' privacy policy can be found on our website [MyMedSupplies.com](http://MyMedSupplies.com).