

ENVISION PHARMACIES

AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS

I, _____ who resides at _____ in the city
of _____ in the state of _____ hereby authorize:

Mail to: EnvisionPharmacies
7835 Freedom Avenue N.W.
North Canton, OH 44720

To disclose the following specific health information by mail or fax or email to:

Name: _____
(Physician, Hospital, Clinic, or other Healthcare Provider, Healthplan, Third Party Admin, Other Payer or Other Party)

Address: _____

City, St., Zip: _____

From the Health or Prescription Drug Records of:

Name: _____
(Name of Individual Whose Health or Prescription Drug Record is Being Disclosed)

Address: _____

City, St., Zip: _____

For the purpose of: _____

My authorization extends only to those data elements/documents initialed below:

- _____ Statements of charges or payments
- _____ Record of all prescriptions filled including name of medication and amount paid
- _____ Record of all pharmaceutical dispensed
- _____ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc)
- _____ Consultation Reports
- _____ All of the above
- _____ Other (Must be specific) _____
