South Valley
PHARMACY SERVICES

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent to this pharmacy to use and disclose protected health information (PHI) about me to provide treatment, services, payment, and health care operations. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. A current notice will be posted in the pharmacy. A revised copy will be provided at your request.

With this consent, you have the right to call my home (or other alternative location) to leave a message on a voice mail or in person in reference to any items that assist in offering treatment, you have the right to email me with any information required to provide treatment or service. You may also mail to my home (or other alternative location) any items that assist in the practice of providing treatment or health care related services.

Under HIPAA regulations, Patients have the right to request that this pharmacy restricts how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

By signing this notice, you authorize this pharmacy to use and disclose information as described herein.

_____
Patient Name (print)

_____ _____
Patient Signature Date

_____ _____
Signature of Legal Guardian (if applicable) Relationship to Patient

South Valley Pharmacy Services
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