VALUE SPECIALTY PHARMACY
1333 Plank Road • Suite 200 • Duncansville, PA 16635
855-265-8008 toll free • 814-283-2211 fax • www.vsprx.com

Authorization for Release of Information to Personal Representative:

This Value Specialty Pharmacy (VSP) authorization is for use if you wish to have a spouse, parent, adult child, or caregiver have access to your medical and health information on an on-going basis to assist with your care and maintaining your information.

If you are requesting VSP to release information to a third-party company (for example: housing authority, insurance company, law office, etc.), then do not use this form. Please contact VSP at 855-265-8008 to request an "Authorization for Release of Information to Third Party" form.

I. Patient Information:

Patient Name: _____

Date of Birth: _____

Street Address: _____

City, Sate, Zip: _____

Telephone Number: (____) ____-_____ E-Mail Address: _____

List the location you obtain most of your
Prescriptions from: _____

II. Person Authorized to receive Information from VSP:

Patient Name: _____

Street Address: _____

City, Sate, Zip: _____

Telephone Number: (____) ____-_____ E-Mail Address: _____

Relationship: _____

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III. Describe or list the information you are asking us to release:

_____

Any and all prescription information related to medical/health services received.

IV. List the specific purpose for requesting this information:

To assist with the management of my care, maintenance of information and administrative functions on my behalf relating to the services/products I receive from VSP.

V. Expiration Date:

This authorization expires annually from the date signed unless otherwise indicated by patient.

I wish this to expire on _____/ _____/_____
Month Day Year

Patient signature: _____

Date: _____

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VI. Information Regarding this Authorization:

- You have the right to revoke this Authorization in writing to VSP Privacy Officer at any time. The revocation is only effective after it is received and logged by VSP. Any use or disclosure made prior to a revocation is not included as part of the revocation.
- Refer to VSP's Notice of Privacy Practices for permitted uses and disclosures of protected health information ("PHI"). You may obtain a copy of this Notice from the VSP Privacy Officer or call 855-265-8008. Please keep a copy of this authorization for your records.
- Once PHI is disclosed to others, it may be redisclosed by them to persons or entities that were not subject to the privacy regulations which means that the PHI may no longer be protected by regulations.
- Privacy regulations prohibit the conditioning of treatment, payment, enrollment or eligibility for benefits on signing this Authorization.
- This Authorization must be signed and dated by the patient or signed and dated by the patient's personal representative. If patient's personal representative signs the Authorization, please provide appropriate documentation and description of that person's ability to act on behalf of the patient.

VII. Signature:

By signing below, I authorize Value Specialty Pharmacy to use or disclose my Protected Health Information as described above.

_____ _____

Signature Date

_____

Printed Name

VIII: Please keep a copy for your records and mail the original signed form to: VSP Privacy Officer, One Golf View Drive, Altoona, PA 16601; Phone: (855) 265-8008; Fax (814) 283-2211

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Authorization to Leave Messages:

I hereby authorize that phone messages and/or text messages are allowed to be left at the number(s) below regarding my prescription services, refills, renewal and delivery:

Phone number Alternate Phone Number

I, _____, by signing below, authorize VSP to leave messages as described above.

Signature Date

Acknowledgment for Receipt of Notice of Privacy Practices

I hereby acknowledge I have received a copy of Value Specialty Pharmacy's Notice of Privacy Practices.

Signature of Patient or Personal Representative

Name of Patient

Date

If Personal Representative is signing for the patient please provide your name, address, documentation and description of your ability to sign on behalf of the patient.

Name: _____

Street Address: _____

City, Sate, Zip: _____

Telephone Number: (____) ___-_____ E-Mail Address: _____

Relationship: _____

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