Ready Meds Pharmacy
Renton • Spokane • Lacey • Everett • Vancouver

REQUEST TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

HIPAA Regulations require Ready Meds Pharmacy to obtain an authorization for certain types of disclosure. Please fax or email completed form to Ready Meds Pharmacy to request patient records.

1. NAME OF PATIENT

Ready Meds Pharmacy is authorized to release information or records regarding:

Patient Name: _____ **Pt DOB:** _____ **Facility Name:**_____

2. DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information requested is:

___ Patient MAR

___Patient Medication List

___Other (please describe) _____

3. REASON FOR DISCLOSURE

The purpose of this use or disclosure is:

_____

_____

4. RECIPIENT INFORMATION

Person or organization authorized to receive information or records:

Name: _____

Relationship to the patient: _____

Phone number:_____

Fax number: _____

Signature: _____ **Date:** _____

Proudly Serving All of Washington State

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Ste C
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