Authorization for Eagle Pharmacy to provide access to Patients Protected Health Information (PHI) to another Individual

This authorization allows Eagle Pharmacy to give access to Patients account to the named individual below. This individual will have access to all Protected Health Information (PHI) as well as have full liberty to act on the Patients behalf when, for example, ordering prescriptions, refills, etc.

- The person you give access to your account will have full access to all records. PHI provided under this authorization may include application or enrollment information, claim records, claim status and patient management information, diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information.
- You may revoke this authorization at any time by notifying us in writing at the address below. The cancellation will apply from the date we receive your written notification.
- You have a right to inspect or copy the PHI described above.
- Please return completed, signed authorization to the address below.

I hereby authorize Eagle Pharmacy and any of its parents, subsidiaries, or other affiliates and their respective employees to disclose Protected Health Information (PHI) of the member/insured listed below to those listed in section 2.

1. Patient Information

Last Name	First Name	MI
Street Address		Birth date (MM/DD/YYYY)
City, State	Zip	Patient Phone Number

2. Authorized Party

Last Name	First Name	MI
Street Address		Birth date (MM/DD/YYYY)
City, State	Zip	Phone Number

3. Signature of Patient

Signature of Patient	Date
Print Name	

Mail form to: Eagle Pharmacy
PO Box 90937
Lakeland, FL 33804

Or fax to: 877-283-9171