elixir
PHARMACY

# AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS

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

**Mail to: Elixir Pharmacy**
**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, Health Plan, 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) _____
_____