elixir
PHARMACY

REVOCATION OF AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS

I, _____ who resides at _____
in the city of _____ in the state of _____ hereby revoke authorization to:

Elixir Pharmacy
7835 Freedom Avenue N.W.
North Canton, OH 44720

to disclose information from the protected health records of:

Name: _____
(Patient)

Address: _____

City, St., Zip: _____

My revocation extends 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 pharmaceuticals 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) _____

This revocation is given freely with the understanding that:

1. Disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, such as for the reporting of communicable diseases.
2. Drug Source, Inc., its employees, officers, and pharmacists are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

_____ _____
Patient's Name Printed Date

_____ _____
Patient's Signature (or Guardian, if a minor) Expiration Date (If 1 year from date above)

_____
Social Security Number (For Identification Purposes Only)

_____ _____
Witness Date