HIPAA Authorization Form

This form authorizes Hair Enterprise LLC, a pharmacy consulting firm, to access and review Protected Health Information (PHI) in collaboration with_____ solely to improve care and fulfill the duties/goals outlined in the partnership. This authorization follows the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The following medical information will/can be accessed:

- Medication History
- Pharmacy Billing Information
- Treatment Plans
- Lab Results Related to Medications
- Health Conditions and Diagnoses
- Other (specify): _____

The purpose of this disclosure is to:

- Facilitate Pharmacy Consultation Services

I authorize the following community health organization(s) and Hair Enterprise to share and receive my PHI:

Community Health Organization Name _____

Contact Person/Title (Print) _____

Signature _____

Phone Number_____

Address_____

I understand that I have the right to revoke this authorization in writing at any time. I acknowledge that the revocation will not affect any disclosures made before Hair Enterprise and the community health organization received the revocation.

****Only the minimal necessary data will be used and disclosed to accomplish the goals outlined in the partnership between Hair Enterprise and the community health organization****