mailmyprescriptions.com™
America's First Wholesale Pharmacy

Release Authorization

Instructions:
This form must be filled out and signed by the patient or by their personal representative requesting the release. Please return the completed form via email to: support@mailmyprescriptions.com or fax to 1-844-862-6121. Should you have any questions about this form, please call 1-800-964-9654.

Patient Name:

☐ **Release of Information**
Complete this section to allow mailmyprescriptions.com to discuss your medications with your designated representative.

I hereby authorize MailMyPrescriptions.com to disclose and release my Protected Health Information (PHI), including prescription and health condition information to the following person(s)

Representative's Name	Relationship to Patient	Phone	Email

This authorization shall be effective until revoked. At any time, you may revoke this authorization in writing or by calling 1-800-964-9654.

☐ **Shared Email Accounts**
Complete this section to acknowledge that your medication information may be visible to persons you share an email account with.

I understand that MailMyPrescriptions.com uses email as a form of communication and that by providing a shared email account address, all persons who have access to that email would be able to view the information in those communications, which may contain Protected Health Information (PHI).

Name of person sharing Email Account	Relationship

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient