

**HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PHARMACY/MEDICAL/HEALTH INFORMATION**

I, \_\_\_\_\_, hereby authorize the use and disclosure of my protected health information as described in this authorization. Specific person/organization (or class of persons) authorized to provide the information: \_\_\_\_\_

1. MSP Solutions, a division of the law firm of Ritsema & Lyon, P.C. is authorized to receive and use the information. They are receiving and using this information in connection with my claim for workers' compensation benefits.
2. I further authorize that a photocopy of this medical release may be used by MSP Solutions, a division of the law firm of Ritsema & Lyon, P.C. to order and obtain requested medical documentation.
3. Specific description of the information: All records, regardless of date, regarding any medications or other prescriptions provided through this pharmacy, including but not limited to prescription names and dates, identity of the doctor issuing the prescription, costs of prescriptions, insurance and payment records, any attendant medical records or reports, and any other records maintained by this facility in regard to issuing or receipt of prescriptions.
4. Specific purpose for the use and disclosure of the protected health information: to determine liability for workers' compensation benefits, including medical and pharmacy benefits, disability benefits, the compensability of my workers' compensation claim, and past or future medical benefits.
5. I understand that I may revoke this Authorization at any time by notifying this pharmacy in writing. I understand that the revocation is only effective after it is received and logged by the pharmacy. I also understand that any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.
6. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my right to obtain prescriptions from the pharmacy.
7. I understand that, after this information is disclosed, federal law might not protect it and the recipient might redisclose it.
8. I understand that I am entitled to receive a copy of this Authorization.
9. This Authorization expires upon the closure of my Colorado workers' compensation claim.

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
Date of Birth \_\_\_\_\_  
SSN \_\_\_\_\_

Store Number: \_\_\_\_\_ Received by: \_\_\_\_\_

Pharmacist: Forward the completed Authorization to your pharmacy Office, Attn: Privacy Coordinator