Rowan Medicine

Authorization For Release of Information

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

Due to new DEA Regulations regarding Controlled Drug Substance Dispensing, some Pharmacies are now requiring the prescribing provider (s) to release the following information to them prior to dispensing these prescribed medications:

Patient Name: _____

Birth Date: _____

To be completed by the Provider's Office:

- Diagnosis: _____
- Medical History: _____

  _____
- Past Surgical Procedures (if Any): _____
- Planned Duration of Current Prescription Treatment: _____

  _____
- Any other pertinent information (if needed pharmacy may call provider to discuss): _____

  _____
- Prescribing Physician: _____ DEA #:_____

To be completed by the Patient or Guardian:

I understand the nature of the authorization and that this authorization can be revoked at any time by the person giving authorization, with a written and dated notice, except to the extent that disclosure made in good faith has already been made prior to receipt of the revocation.

If the above information is not sufficient and additional information is required, I give NMI permission to release my last 2 office visit notes and my current medication list to the Pharmacy listed below.

I hereby request and authorize Rowan Medicine NeuroMusculoskeletal Institute (NMI) to disclose the above information to:

Name of Pharmacy: _____

Address: _____

Phone Number: _____Fax Number: _____

Printed Name of Patient or Guardian:_____

Signature of Patient or Guardian:_____ Date:_____