Eagle Pharmacy Prescription History Request Form

You must complete this form to request a copy of your prescription history. If you are the **Personal Representative** for the patient (an individual with legal authority to make prescription decisions on the patient's behalf), we must have the necessary document on file showing this authority or it must be included with this form. A **separate** authorization form **must be** completed for **each** patient requesting their Eagle Pharmacy prescription history.

Please complete the following information:

Last Name **First Name**

Date of Birth (mm/dd/yyyy) **Phone Number**

Street Address

City **State** **Zip Code**

Prescription History Dates: **From** / / (mm/dd/yyyy) **To:** / / (mm/dd/yyyy)

I authorize Eagle Pharmacy to disclose my health information in the following manner:

☐ **Fax my information to the following PRIVATE fax number:** - -

☐ **Email my information in a zipped (secure) file to the following email address:**

I have WinZip® in order to open the document. I understand that once I receive the file, an Eagle Pharmacy representative will call me with the password to open the document.

Call me at the following phone number: - -

☐ **Mail my information to me at the following address:**

Street Address

City **State** **Zip Code**

I authorize the disclosure of my health information, as described below.

I understand that this health information may include HIV-related information and/or information relating to substance abuse treatment and/or mental health diagnoses and treatment. By signing this form, I authorize that such information be disclosed.

This information is being disclosed at my request for my own purposes. I understand that I may revoke this Authorization in writing at any time, except to the extent that Eagle Pharmacy has already taken action in reliance on this Authorization. I understand that I am not required to sign this Authorization as a condition of treatment, payment, enrollment, or eligibility for benefits.

By signing below, I acknowledge that I have read and understood this Request Form.

Signature of Patient or Patient's Personal Representative

Date

Print Name of Personal Representative

Relationship to Patient