CSI CLINICAL SPECIALTY INFUSIONS

Authorization to use and disclose Protected Health Information (PHI)

I hereby authorize Clinical Specialty Infusions of Dallas, LLC dba CSI Pharmacy to disclose my Protected Health Information (PHI) as contained in the Designated Record Set maintained by CSI Pharmacy, including but not limited to highly confidential information concerning communicable diseases, HIV, AIDS, psychiatric, chemical or alcohol dependency, laboratory test results, or any other medical treatment. I am aware that CSI Pharmacy may contact me for authentication and verification using the contact information I provided.

I understand that I have the right to revoke this authorization at any time, in writing, via email, fax, or mail. I understand this authorization will expire in five years unless I revoke the authorization; this authorization is voluntary, and CSI Pharmacy will never condition treatment, payment, enrollment, or eligibility for benefits on this authorization; and any of my information that is disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

1. Patient/member information (please provide current information)

Last Name _____ First Name _____ MI _____

Mailing street address _____ Apt. # _____

City _____ State _____ ZIP _____

Member ID number _____ DOB _____

Phone number with area code _____

2. Requested information criteria

Type: ____ Medical records ____ Billing records ____ Payment records
____ Claims Adjudication ____ Enrollment information ____ Medication History
____ Other: _____

Health information that may be disclosed is limited to the following treatment dates/events:

_____

Name of Recipient: _____

Manner of Delivery (please include method and address if applicable): _____

_____

Purpose of Release/Disclosure: _____

3. Signature

I have read and understand the above information. I acknowledge that by signing this form, I understand that my decision of whether or not to sign this form will not affect my eligibility for treatment or payment and am

voluntarily giving consent to CSI Pharmacy and its affiliates to use and/or disclose my PHI to the recipient designated in Section 2.

Signature of member or patient: _____ Date: _____

4. Return the completed form

Mail completed form to:	Email completed form to:	Fax completed form to:
CSI Pharmacy 459 East New Boston Rd. Nash, TX 75569	Release@csipharmacy.com	430-200-4889

Please note: Information sent via email is not encrypted, so a third party may be able to access emailed information and read it since it is transmitted over the internet. In addition, once a email is received by you, someone may be able to access your email account and read it. If you request your PHI via email, you acknowledge that you understand and accept the associated risks.