



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____

I request and authorize AuBurn Pharmacy to release healthcare information of the patient named above to:

Name: _____

Email: _____

This request and authorization applies to:

Online access to the prescription list for the patient named above.

Online access to the drug profile for the patient named above.

Online access for refill requests for the patient named above.

Patient Signature: _____ Date: _____

By signing this I certify that I am the patient named above and this is my signature