



825 East Burgess Road, Pensacola, Florida 32504
 850.473.9190 Fax 850.473.9935
 www.PensacolaApothecary.com

Pharmacy Record Release Authorization

I, the undersigned patient authorize my pharmacist to release my personal medication and/or other medical information to the following persons or organizations upon request or as deemed necessary:

Name	Address	Telephone
1)		
2)		
3)		

I understand that employees of _____ Pharmacy will protect my privacy and this information will be released to other health care professionals only when it is necessary in order to provide health care services to me. This authority shall continue until revoked by me in writing.

Patient Name: _____

Address: _____

City, State, Zip _____

Phone: _____

Signature: _____

Date: _____

Patient Name: _____
