Request for Prescription Record Printout

As part of the Federal Government's HIPAA (Health Insurance Portability and Accountability Act of 1996), we are required to have each adult (defined as persons 18 years and older), fill out this form in order to obtain medical records or histories. Parents and care-givers of persons under 18 may obtain records for them after filling out this form. Taylor Drug cannot release medical information protected under HIPAA to anyone except the patient (**even spouses and adult children**). Please provide the following:

Name:_____ **Date of Birth:** _____/_____/_____

Address:_____

City:_____ **State:**_____ **Zip:**_____ **Phone:** (_____) - _____ - _____

Dates Requested: _____/_____/_____ to _____/_____/_____

If picking up medical records for you minor children, please provide the following information:

Spouse's Name:_____ **Date of Birth:**_____/_____/_____
(Only required if picking up his/her records. **Required signature below**)

Minor's Name:_____ **Date of Birth:**_____/_____/_____

Minor's Name:_____**Date of Birth:**_____/_____/_____

Minor's Name:_____ **Date of Birth:**_____/_____/_____

Minor's Name:_____ **Date of Birth:**_____/_____/_____

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Minor's Name:_____ **Date of Birth:**_____/_____/_____

Minor's Name:_____ **Date of Birth:**_____/_____/_____

Minor's Name:_____ **Date of Birth:**_____/_____/_____

If any of the above dependent children live at a different address than listed above, please provide that information below, and circle the name of any and all children living at the different address:

Address:_____

City:_____ **State:**_____ **Zip:**_____

Signature:_____ **Date:**_____/_____/_____

Spouse's Signature:_____ **Date:**_____/_____/_____
(Required only if obtaining his/her records)

By signing, you declare that the above information is correct and accurate. You are responsible for any false or misleading information provided.