AUTHORIZATION TO EXCHANGE INFORMATION

I hereby authorize _____ at Rainbow Health to exchange information regarding:
(name)

_____ with _____
(name) (date of birth)

_____ _____
(organization/pharmacy/individual) (phone number)

_____
(address)

NOTE: Client to initial each item indicating authorization or write "N/A" if not applicable.

Purpose to provide and coordinate services including:

____ Verification of diagnosis

____ Medical information related to date of diagnosis/information regarding ongoing medical care, and prescription transfer to mail order pharmacy

____ Services provided by Rainbow Health

____ Psycho-social factors including, but are not limited to, housing, financial status, hospitalizations, home care needs, and alcohol and drug use.

____ Medical history

____ Chemical Health assessment, diagnosis and recommendations

____ Mental health/psychological history

____ Program eligibility verification

____ Coordination of care

Other information includes:

- I understand that this information will be kept in a confidential manner by Rainbow Health staff and trained volunteers.
- I have been informed of my right to refuse to allow Rainbow Health to exchange this information.
- I understand that I may revoke this consent upon written notice. The revocation will be effective the day it is received by the staff named on this release or his/her successor.
- I understand that information shared prior to revocation can't be retracted.
- I understand that when health information is released, it could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.
- I understand a photocopy or fax of this form is the same as the original.
- I understand I may have a copy of this form after I have signed it.
- I understand that information may be exchanged via phone, fax, email, or a meeting with a provider.
- I understand that the consent will automatically expire within one year after the date of my signature below if an earlier date is not specified.

_____
Name (please print)

_____ _____
Signature Date

This document is available in alternate formats upon request.

Prescription Transfer Request Form:

Client Details

Legal First Name: _____ Legal Last Name: _____

Preferred Name: _____ Phone: _____

Email: _____ Birthdate (XX/XX/XXXX): _____

Please check your preferred contact method:

Phone ___ Email ___ Is it okay to leave a voicemail: Yes ____No____

Pharmacy & Rx Details

Name of current pharmacy: _____

Pharmacy phone number: _____

Prescribing doctor's name: _____

Transfer all Rx: Yes____ No____
If no, please complete the following:

Rx Numbers of Prescriptions:

Fax completed form to:
Avita Care Solutions
Fax#803-358-3034, subject: Rx Transfer Request
Avita toll free ph#866-437-6717