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### Kenyon College Health Center Patient Information and Delivery Agreement

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ M F

Kenyon PO Box: \_\_\_\_\_ Student Mobile Number & Provider: \_\_\_\_\_

Student E-Mail: \_\_\_\_\_ Medication Allergies: \_\_\_\_\_

Do you want to be enrolled in our auto-refill program (**only for non-controlled medications**)?

\_\_\_\_\_ YES \_\_\_\_\_ NO

Home Address and Zip Code: \_\_\_\_\_

Parent Phone Number: \_\_\_\_\_

### Patient Contact Authorization Form

Respect for your privacy is a top priority at Eastside Foster's Pharmacy (EFP). Eastside Foster's Pharmacy practices in compliance with federal regulations that are part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which addresses your rights to privacy and handling of Protected Health Information ("PHI"). We have patients request that we leave detailed voice messages about their prescription or we have patients notify us that a friend or family member will be picking-up their prescription. While we try to accommodate our customers, we also must adhere to HIPAA regulations. The form below will allow us to leave voice messages at specific telephone numbers, authorize prescription pick-up contacts, and release information about you, the patient, to those authorized by you. (This required for those patients 18 and older).

#### **Can Eastside Foster's Pharmacy leave voice messages at the numbers you provide below? (Please circle your choices.)**

Student Mobile Phone: \_\_\_\_\_ Yes / No Detailed or Basic Message Authorized

Parent Phone: \_\_\_\_\_ Yes / No Detailed or Basic Message Authorized

These individual(s) have been selected by the patient listed above as an authorized contact for the specified information.

1.) \_\_\_\_\_

*Authorized Contact Full Name (Print) Telephone Relation*

**Information to Be Released to Contacts:** Patients are to select information and/or items that the above individual(s) listed can receive and are authorized to know. **Please INITIAL by all items or information that can be released to the above individual(s).**

- \_\_\_\_\_ Medical Information (Any information regarding your health diagnosis and treatment plans, etc.)
- \_\_\_\_\_ Financial Information (Any information regarding your insurance, payment plans, credit & balances, etc.)
- \_\_\_\_\_ Prescription Pick Up (All individuals who are picking up prescriptions must show a form of identification.)
- \_\_\_\_\_ Documentation Pick Up (All individuals who are picking up any documentation must show a form of identification.)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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#### **Authorizing Patient Information NOT to be Released – (for patients 18 years and older)**

By signing this section below, you are choosing **NOT to release ANY of the above information to ANY individual(s) other than yourself.** This means that spouses, children, family members, etc. cannot pick-up prescription(s) or access any information regarding your prescription(s) filled at EFP.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- I agree to have Foster's Eastside Pharmacy fill and arrange for delivery of my prescriptions to my Kenyon College mailing address.
- I understand and agree to cover all prescription cost/copays and delivery charges (\$5.00) with the form of payment provided below. I understand EFP will charge my credit card for the above referenced charges. In the event my form of payment does not allow approval of charge, EFP has the right to cancel/hold delivery of my medication and attempt to notify me of such cancellation. If no approval is made by 3pm Monday-Friday my medication will not be delivered that same day.
- I understand that EFP WILL NOT exchange medication or return any monies paid once on any order that was shipped. This is pursuant to State pharmacy law OAC 4729-9-04. I understand I must check my designated PO box before end of academic year and academic breaks and that EFP cannot return any medications if not picked up or return any payments.

**CREDIT CARD AUTHORIZATION**

Name on Card: \_\_\_\_\_ Billing Address: \_\_\_\_\_

\_\_ Visa \_\_ MC \_\_ AMEX \_\_ Discover

Card Number \_\_\_\_\_ Expiration \_\_\_\_\_ Security Code \_\_\_\_\_

\_\_\_\_\_ I authorize Eastside Foster's Pharmacy to charge my credit card for prescription and delivery charges. I understand and agree that I responsible for all the charges for prescriptions and delivery services rendered from EFP.

**X**

\_\_\_\_\_  
Cardholder/Patient Signature & Date

**CONFIDENTIALITY AND NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices (NOPP) of Eastside Foster's Pharmacy, posted in the pharmacy or have been given my own copy. I acknowledge that I agree with the patient authorization information provided above.

I understand that Eastside Foster's Pharmacy, through its HIPAA policies is obligated to protect my confidential personal health information. I have the right to request to see their HIPAA policies at any time. Eastside Foster's Pharmacy reserves the right to change the terms of its Privacy Notice. If such changes are made, I understand that the Privacy Notice will be posted on the EFP website and I can request a copy at any time.

I understand that I am responsible to provide current and accurate insurance information to Eastside Foster's Pharmacy and a copy of their current insurance card. I also understand that a delay in getting current and accurate insurance information to the pharmacy will result in a delay in getting my prescriptions. I understand that I may also get an option to pay out-of-pocket for prescription(s) if I cannot obtain current and accurate insurance information in a timely manner.

**I verify by my signature below that I give permission for prescription(s), over-the-counter item(s) and delivery services; I have been informed of my privacy rights; I am responsible for charges on my credit card and authorize of my health informtion to process any insurance claims.**

\_\_\_\_\_  
**Signature of patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of parent (if patient is under 18)**

\_\_\_\_\_  
**Date**

