1810 Summit Commerce Park
Attn: Medical Records Requests
Twinsburg, Ohio 44087
Fax: 614-652-0315
Email: GMB-EPRcdsREq@cardinalhealth.com

RGH ENTERPRISES, LLC dba EDGEPARK MEDICAL SUPPLIES
AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____
Last **First** **Middle**

Home Address: _____
_____

Home Phone: _____ **Date of Birth:** _____

SPECIFY INFORMATION TO BE DISCLOSED: Please indicate the protected health information to be used or disclosed by placing a check by those that apply and as applicable, by completing the date from and date to lines. This Authorization may not be used for the release of Psychotherapy notes.

☐ **Medical Records from (insert date)_____ to (insert date) _____**
☐ **Billing Records from (insert date)_____ to (insert date) _____**

RECIPIENT: Name of person or class of persons to whom **RGH Enterprises, LLC dba Edgepark Medical Supplies ("Edgepark")** may disclose my health information:

Name: _____

Address: _____

Phone Number: _____ **Fax:** _____ **E-mail:** _____

TERM: This Authorization will remain in effect:
☐ From the date of this Authorization until_____, 20__
☐ Until Edgepark fulfills this request
☐ Until the following event occurs: _____

PURPOSE: I authorize Edgepark to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s):

☐ At the patient's request
☐ Other (describe)

_____

I understand that once Edgepark discloses my health information to the recipient, Edgepark cannot guarantee that the recipient will not re-disclose my health information to a third party. Further, the third party may not be required to abide by this Authorization or applicable federal law governing the use and disclosure of my health information.

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I understand that I may refuse to sign or revoke (at any time) this Authorization for any reason in writing by sending such written notification to privacy@cardinalhealth.com or to Cardinal Health, Inc., Attn: Edgepark Privacy Department, 7000 Cardinal Place, Dublin, Ohio 43017. If I revoke this Authorization, it will have no effect on actions already taken by Edgepark in reliance on this Authorization.

I understand my refusal or revocation of this Authorization will not affect my treatment, payment, enrollment, or eligibility for benefits from Edgepark; except, however, if my treatment at Edgepark is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Edgepark may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the earlier of (i) the term of this Authorization expires or (ii) my written notice of revocation to Edgepark's Privacy Department. The revocation will be effective immediately upon Edgepark's receipt of my written notice, except that the revocation will not have any effect on any action taken by Edgepark in reliance on this Authorization before Edgepark received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly, and voluntarily, authorize Edgepark to use or disclose my health information in the manner described above.

Signature of Individual or Personal Representative: _____

Printed Name of Individual or Personal Representative: _____

Description of Personal Representative's Authority: _____

Phone:_____

Date: _____

****Please provide Power of Attorney and Court Order Appointing Representative (if applicable)***