MIT Medical Department
Pharmacy ▪ Building E23-197 ▪ 77 Massachusetts Avenue ▪ Cambridge, MA 02139-4307 ▪ Tel: (617) 253-1324 ▪ Fax: (617) 258-9360

Release for Pharmacy Patient Prescription Profile

Please fill in the form completely

1 _____

Patient's Last Name First Name Middle Initial Date of Birth Former Name, if any

_____

Medical Record Number
or MIT ID Number

2 I authorize the MIT Medical Department to release pharmacy records to:

_____

Name and Address

3 Reason for Disclosure:

□ further medical care	□ payment of insurance claim	□ legal investigation
□ applying for insurance	□ vocational rehab evaluation	□ other - specify:
□ disability determination	□ personal	_____

4 Check one:
□ Mail prescription profile to name and address above.
□ I will return in person to pick up the prescription profile.

5 Date(s) of prescription profile requested: ____ \ ____\ ____ to ____________.

6 This authorization is valid for one-time access to the prescription profile and expires in thirty (30) days from request.

7 I authorize release of my prescription profile as specified above. I understand that the only way to cancel this request is to notify the MIT Medical Department Pharmacy in writing.

8 Signature of Patient _____ Date _____

If signed by anyone other than the patient, state relationship and/or reason and legal authority to do so:

Patient is: □ a minor □ incompetent □ disabled □ deceased
Legal authority: □ legal guardian □ next of kin of deceased

For MIT Medical Use Only:
Date received _______________ I.D. provided _____
Date released _______________ Processed by _____

□ Sent by mail □ Picked up in person