Cooper Green *Mercy* Health

AFFILIATE OF UAB HEALTH SYSTEM

Name (Please Print): ______________________ Birthday: ______________

Cooper Green Medical Record Number: ______________________

Mailing Address: ______________________

Phone Number: ______________________

Authorization for Release of Protected Health Information and/or Financial Information

This authorization for release of protected health information and financial information is for the purpose of participating in the Prescrption Assistance Program. This form will expire one year from your enrollment date at Cooper Green Mercy Health Services Authority (Authority). I hereby authorize the disclosure and use of my personal health information as described above. I authorize the Authority to release my personal health information concerning treatment and diagnosis.

______________________ ______________________

Patient/Legal Representative Signature Date

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Patient Printed Name

Authorization for Patient Assistance Program

I hereby authorize the representatives of Cooper Green Mercy Health Services Authority to sign me up for the sole purpose of obtaining medication that I have/will use from the prescription assistance programs, for which I am deemed eligible.

______________________ ______________________

Patient/Legal Representative Date

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Patient Printed Name

For Office Use Only			
Patient Called	Medication Requested	Household Size	Income