# UAMS SPECIALTY PHARMACY SERVICES

## RELEASE FORM

### Request for Specialty Services

I understand that by signing this form I am enrolling for services provided by the University of Arkansas for Medical Sciences Specialty Pharmacy Services. The services provided include all or some of the following:

- Monthly outreach calls to check on my wellbeing and the need for refills of my medications prescribed by my UAMS physicians.
- Calls regarding financial assistance or reimbursement issues
- Calls or mail with educational information regarding my prescribed therapy from the manufacturer of my medicine.

### Financial Responsibility

I understand that I am responsible for the payment of bills associated with my prescriptions. I understand that my insurance company will be billed for the medication and I will be responsible for any copay. In the event my insurance will not cover my medication, I understand that once dispensed, I will be responsible for payment in full. I understand that it is my responsibility to know my insurance company's benefits and that I can find this information by calling my insurance company.

### Release of Information

I authorize all my health care providers, insurers and anyone else with information about my healthcare to release all of my records to UAMS that are related to my treatment. I authorize the use of my medical records to determine coverage of my medications by my insurance company as well as for drug utilization review, quality control and report generation. I authorize UAMS to release the information in my records as necessary to receive payments or obtain benefits for me and to speak with my other health care providers if necessary regarding my treatment. I understand that my information may be used to comply with audit regulations established by the government or accreditors. I understand that information that does not identify me personally (blinded) may be used for data purposes by UAMS. UAMS, its employees and attending physicians are released from legal responsibility or liability from the release of my information as indicated and authorized above.

### Manufacturer Assistance Programs

I authorize UAMS to enroll me and talk with me about manufacturer assistance programs available for my prescribed medication. I authorize UAMS to release my information pertaining to the therapy to the manufacturer to obtain services and educational materials available through the manufacturer. Information that does not identify me personally may be used by the manufacturer for marketing analysis. I understand that I may revoke this authorization at any time by sending a written request to:

UAMS Specialty Pharmacy Services
4301 W. Markham St., Slot 547/10
Little Rock, AR 72205

# Authorization To Speak On My Behalf

I authorize the following people to speak on my behalf about my prescription services, refills, renewals and delivery.

| | |
|---|---|
| Print Name | Relationship |
| Print Name | Relationship |

**Authorization To Leave Messages**

I authorize that phone messages about my prescriptions may be left and that text messages are allowed for the phone numbers listed below. I understand that these messages are not secure and may lead to unintentional disclosure of my information.

| | |
|---|---|
| Primary phone number | Secondary phone number |

**Child Resistant Packaging**

I understand that some medications are not available in child proof packages. I accept responsibility for the use of my medications and will not hold UAMS liable for the unintended or accidental use of my medications regardless of packaging.

**Notice of Privacy Practices/Patient Bill Of Rights**

I acknowledge that I have received a copy of UAMS Notice of Privacy Practices and a copy of UAMS Patient Bill of Rights and understand the information. I understand that I may request a copy of these documents at any time and ask questions about anything I do not understand.

**Patient Bill Of Rights**

I understand that I am not required to sign this form in order to receive services, but I will not be enrolled in or receive information about assistance programs. If I do not sign, I am still subject to the terms in the Financial Responsibility, Release of Information, Child Resistant Packaging and Patient Bill of Rights.

By signing below, I certify that I have read and agree to the terms included in this agreement and that I am the patient or I am authorized as the patient's agent.

Patient/Patient's Agent Signature: _____ Date: _____

Relationship to Patient:_____

Print Patient Name: _____ Date of Birth: _____