PANEL XX

Form Approved
OMB No. 0935-0118
Exp. Date XX\XX\XXXX

AUTHORIZATION TO OBTAIN INFORMATION FROM PHARMACIES AND PHARMACY RECORDS MEDICAL EXPENDITURE PANEL SURVEY – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

A. Provider Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____ - _____
Area Code

B. I am voluntarily participating in the Medical Expenditure Panel Survey (MEPS), a study of health care use and expenses being conducted by the U.S. Department of Health and Human Services. I authorize and request that you provide the U.S. Department of Health and Human Services and its contractors with the medical and financial information they request about prescriptions filled or refilled for my use during the period January 1, 20XX to December 31, 20XX. This authorization form applies to any and all prescribed medicines received by me during this period, including medicines prescribed for the treatment of mental health, alcohol, drug abuse, STD, HIV, AIDS, or Sickle Cell Anemia.

I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA)(1) prohibits you from releasing my information without my authorization. This form (or a photocopy of this form) gives you my authorization. I have signed this form voluntarily, with the understanding that my decision to sign or not to sign the form will have no effect on my eligibility for treatment, payment, enrollment, or eligibility for any benefits to which I am entitled.

I understand that the Department of Health and Human Services and its contractors will use this information to supplement the information I have already given for MEPS research on health care use and expenditures. I also understand that once my information is released to the study, it is no longer covered by HIPAA but is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)], which provide that information that could identify me will not be disclosed unless I have consented to that disclosure.

I authorize the study to use information I have given in the survey to help you identify my records. I also understand that I can revoke this authorization at any time by contacting a study representative in writing or by telephone, but that my revocation will not affect disclosures already made by a provider relying on my authorization. Otherwise, this authorization expires 30 months from the date of signature.

C. 1. Patient Name: _____

2. Date of Birth ____ / ____ / ____
Month **Day** **Year**

3. Other Names Under Which Records May be Filed _____

D. 4. _____
Patient's Signature - 14 and over sign

5. Date Signed _____

IF PATIENT IS 14-17, BOTH PATIENT AND PARENT/GUARDIAN MUST SIGN AND DATE.

E. 6. _____
Parent, Guardian, Witness or Proxy's Signature

7. Date Signed _____

8. _____
Signer's Relationship to Patient

9. Reason for Parent, Guardian, Witness or Proxy's Signature:
- ☐ Patient 13 or Younger
- ☐ Patient 14-17 Years Old
- ☐ Patient Disabled
- ☐ Patient Deceased

FIELD USE ONLY: RU ID: _____ REGION: _____ PROVID: _____ PID: _____

(1) Health Insurance Portability and Accountability Act: 42 U.S.C. 1320d-2 and 1320d-4 and the implementing regulation, 45 CFR 164.508, require a detailed authorization for your health care provider to disclose health information from your records for research purposes.

Public reporting burden for this collection of information is estimated to average 3 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-0118) AHRQ, 540 Gaither Road, Room # 5036, Rockville, MD 20850.

_____ **SCAN:** ☐ **Yes** ☐ **No** _____
CODE **FIID**