Sarasota Neurology, P.A.
Daniel Kassicieh, D.O.
3501 Cattlemen Road, Ste. B
Sarasota, FL 34232

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

I authorize Dr. Kassicieh and his staff to submit my patient information to my Pharmacy Benefit Manager for the purpose of assisting my healthcare provider in managing the prior authorization or other coverage determination process for prescription drugs. This information may include but is not limited to my name, date of birth, address and contact information, my medical condition, my treatment history, including prescription medications, my health insurance information, and/or financial information. This information is considered Protected Health Information ("PHI"), and is subject to local, state and federal regulations, and the HIPAA Privacy Rule, located at 45 CFR Part 160 and Subpart A and E of Part 164.

Once my PHI is submitted to my Pharmacy Benefit Manager, I understand that it will be used to submit coverage determinations to my health plan, and may be shared with related physician or pharmacy staff involved in my care. I understand that my information will be used only to the extent necessary to submit coverage determinations, and will no be published to those not involved in my care, however, I acknowledge that once my PHI is disclosed to third parties, it may no longer be subject to protection under the HIPAA Privacy Rule.

This authorization will be in effect until I notify Dr. Kassicieh or his staff that I do not want my information to be disclosed to my Pharmacy Benefit Manager. I understand that I can revoke this authorization at any time, that I am not required to sign this form, and that my healthcare provider cannot condition treatment or eligibility for benefits on my execution of this authorization. I understand that I have a right to receive a copy of this form.

Further, I understand that Sarasota Neurology, et al. utilizes an electronic prescription service (SureScripts) and also runs an eligibility check on my prescription coverage to maximize use of my insurance formulary. I authorize Sarasota Neurology, et al. to access my previous prescription history through this service to assist in making decisions about my health care.

_____	_____
Patient Name (Print)	Patient Signature
_____	_____
Relationship if other than Patient	Signature

_____, 20____
Date Initiated