

**DENIAL FORM**

I confirm that I have read and fully understand **THE HIPAA Notice of Privacy Practices**.

I fully understand that if I refuse consent for Mega Aid Pharmacy employees and staff to access my protected health information, Mega Aid Pharmacy may not be able to access critical health information about me obtained during a prior encounter, in a timely manner.

**I understand by signing this form that by limiting Mega Aid Pharmacy's access to my PHI, Mega Aid Pharmacy will not be able to provide services to me.**

**Name of Patient (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Address:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Record Number:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| Signature |  | Date |
|  |  |  |
|  |  |  |
| Relationship To Patient if Signed By Legal Representative |

If you have any questions regarding this form, please contact the Privacy Officer.