

Information and Release Form - Patient Assistance Program Medications

Name: _____ ID#: _____ Date _____

Email: _____@sfsu.edu Phone # _____ cell ___ home ___

Address: _____

Annual income _____ Do you have health insurance? Yes _____ No _____

Prescriber _____ Rx _____ Dosage _____

CONSENT TO RELEASE INFORMATION

_____ I understand that disclosure of my Personal Health Information is required to assess my eligibility for the Patient Assistance Program.

_____ Unless otherwise specified, this release expires within 180 days of the above noted date, or on _____.

_____ I understand that I may revoke this authorization at any time before expiration of the authorization. The revocation must be in writing, signed by me or my representative, and delivered to the Student Health Service.

_____ I understand that the recipient may not lawfully use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically requested or permitted by law.

_____ I hereby authorize the release of personal health information by the SFSU SHS to Patient Assistance Programs.

Patient Signature

Date of authorization

REMINDERS!!

- The SHS Referral Coordinator will use the information provided above to initiate your application for free medications through a pharmaceutical company's Patient Assistance Program.
- If the SHS Referral Coordinator needs further information, they will contact you at your sfsu.edu email which provides a secure link to their message in Confidential Communicator.*
- ***IMPORTANT:** All email communication will be sent to your sfsu.edu address with the subject line reading "Student Health Service - important message." This email will provide you the link to Confidential Communicator where you will need to log in with a user name and password to access the message. For more information on Confidential Communicator and the process of logging in please see http://www.sfsu.edu/~shs/Clinic_Services/Confidential_Communicator.
- When your application is sent to the Pharmaceutical Company, you will receive an email with the Confidential Communicator link to your secure message. This message will advise you that your medications are to be mailed directly to the address you have listed above or that they will be delivered to the SHS (will depend on the pharmaceutical company).
- If your medications are received by the Student Health Service, you will receive an email with the Confidential Communicator link to advise you when and how to pick them up.
- **REFILLS:** Read the information that is sent with your medications. It will instruct you how and when to request refills. **Requesting refills of your medications is YOUR responsibility. SHS will not send you any other reminders.** If you do not request the medications at least 3-4 weeks before your medication is due to run out, you may not receive them in time and will be financially responsible for refills.

I have read and understand this information. Patient's Signature _____

Attach your prescription to one copy of this form and drop into the Patient Forms Drop-off box.
The drop-off box is located on the kiosk counter next to the SHS Information Desk.

Remember to keep a copy of this form for yourself.
SHS FAX: 415-338-2278 Attn: Referral Coordinator