edgepark® Medical Supplies

1810 Summit Commerce Park
Twinsburg, Ohio 44087
Phone: 1-800-321-0591
www.edgepark.com

Account Number	
Patient Name	
Address	
City, State, Zip	
Date of Birth	

Don't Miss Out on Product Samples and Other Important Information About Your Supplies!

Edgepark provides our customers with a variety of order reminders, product samples and educational information. However, federal regulations prohibit us from sending many of these important benefits to you unless you authorize Edgepark, in writing, to send them. It only takes a minute to electronically sign and date this form.

If the patient is physically or mentally unable to sign, a representative may sign on the patient's behalf.

Please indicate if you are the patient or a representative of the patient.	

I authorize Edgepark to use or disclose my protected health information in order to communicate with me regarding treatment options or other health-related products or services, for which Edgepark may receive a payment.

Email	
Date	
Signature	

This authorization does not affect Edgepark's ability to send "transactional communications," such as those notifying you of product recalls or requesting information prior to order shipment, or communications for which Edgepark does not receive a payment. This authorization will expire 18 months following the last date you have ordered from Edgepark, or at any time you choose to revoke this authorization by calling 1-800-321-0591, ext. 3151. Edgepark may not condition your treatment, payment, enrollment or eligibility for benefits on whether you choose to sign this authorization.

Edgepark does not provide your personal information to our manufacturer partners; however, we may provide your information to a third party printer/mailing house for the purposes of sending you the communications as described above. By law, we are required to notify you that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and thus no longer protected by the Health Insurance Portability and Accountability Act (HIPAA).

If you are a Representative signing on behalf of a Patient please fill in all of the below information:

Representative's Name	
Representative's Address	
Relationship	
Reason Patient Cannot Sign	