Authorization for Disclosure of Personal Health Information

Your Name and Identification Information:

Name: _____ D.O.B: _____Age:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Member ID #: _____

Purpose:

Please read carefully and fill out all required information, to authorize disclosure of personal health information (PHI), which may include; health information, to persons/organizations outside of RxPreferred Benefits. Your privacy is protected by federal and state law, thus, we need your permission to disclose any information to outside parties. Please complete every section in this form.

Persons/Organizations to disclose member information:

Please include full name, and contact information (including: name, address, telephone number, etc.)

_____

_____

What personal health information can we disclose?

Please be specific on what we are allowed to disclosed to persons/organizations, such as; prescription history, description of benefits, or "as requested by the organization or person." Once information is disclosed RxPreferred Benefits is not responsible how the information is used.

_____

_____

Please describe the purpose of the disclosure:

_____

_____

Expiration Date:

This form expires 90-days after the sign date.

Signature:

By signing this document I am authorizing RxPreferred Benefits to disclose information to the persons/organizations listed above. I understand the information disclosed will only pertain to the reasons stated above, and RxPreferred Benefits will only disclose the minimum necessary. I also understand I am under no obligation to sign this authorization. I also understand the services provided by RxPreferred Benefits will not be affected by signing this authorization. I fully understand my rights and risks in signing this form.

Signature: _____ Date:_____

Note: If you are acting on behalf of a member, you must provide legal documentation supporting legal authorization on patient's behalf.

Disclosure:

Once the information is disclosed to the persons/organizations listed by you, the information is no longer protected by federal or state laws. RxPreferred Benefits can no longer control the information, nor can we control what the persons/organizations do with it. We will not disclose certain types of information (such as behavioral health and HIV/AIDS information) unless specified by member or permitted or requested by law. You have the right to revoke the granted access at any time. However, if the revocation occurs after the information is provided to persons/organizations this will not apply since you initially provided permission. You may revoke by submitting a written notice (verbal notice will not be accounted for), by mail or email, no explanation required.

For further questions or to revoke the Authorization form contact:

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Mt. Juliet, TN. 37121
Phone: 888.666.7271 / Fax: 615-823-7757