HIPAA Authorization to Use or Disclose Protected Health Information

MEMBER INFORMATION

Last Name _____ First Name _____ Middle _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Member Number (see ID card) _____ Group Number (see ID card) _____

PHI DISCLOSURE

I authorize my protected health information (PHI) to be disclosed to the following person(s) or entity(ies):

First Name	Last Name	Phone Number	Relationship

The purpose of this disclosure is:

Further Medical Care

Personal Use

Other (specify): _____

INFORMATION THAT CAN BE RELEASED (I allow the following information to be used or disclosed)

CHECK ONE:

- **All My Information** – This can include, but is not limited to: health information, such as diagnosis (name of illness or condition), claims, names and other information about doctors and other healthcare providers, and/or financial information (e.g. billing, EOBs).
- **Only Limited Information** (check all boxes that apply):

Prior Authorization Information	Mail Order Prescription Information
Billing Information	Retail Prescription Information
Eligibility and Enrollment Information	Other (specify): _____

I understand the information that I authorize to be used or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health, or substance abuse.

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RIGHT TO REVOKE

I understand that I may revoke this authorization in WRITING submitted at any time to WellDyneRx, P.O. Box 90369, Lakeland, FL 33804, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy or the policy itself. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

Other date or event: _____

ADDITIONAL INFORMATION

I understand that WellDyneRx and/or its affiliates will not condition treatment, payment, or eligibility for care on my providing this authorization.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).

AUTHORIZED SIGNATURE

I have read and understand the contents of this form and I hereby authorize WellDyneRx, and/or its affiliates, to disclose my protected health information (PHI) to the person(s) or entity(ies) I have listed above.

_____ _____

Signature of Member or Legal Representative | Date

_____ _____

Legal Representative (print full name) | Legal Relationship to Member

If this form is signed by someone other than the member, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following: a copy of a health care, general or durable power of attorney, or a court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please return the completed form by mail to:
WellDyne, P.O. Box 90369, Lakeland, FL 33804-0369 / Fax Number: 1-863-686-5072