Prescription History Request - Mail Order

Complete this form to request your mail order prescription history. If you are the patient's Personal Representative (an individual with legal authority to make mail order decisions on the patient's behalf), WellDyne must have the necessary document on file showing this authority or it must be included with this form. A separate request form is required for each patient. For a retail prescription history, please visit your retail pharmacy.

Patient Information

Last Name | First Name | Mid Initial | Date of Birth

Street Address | City | State | Zip Code

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

Prescription History Dates

From: _____ / _____ / _____ (mm / dd / year)

To: _____ / _____ / _____ (mm / dd / year)

Authorization

Check one:

- ○ Fax my information to the following private fax number: _____
- ○ Mail my information to:

Last Name | First Name

Street | City | State | Zip

I authorize the disclosure of my health information, as indicated above.

I understand that this health information may include HIV-related information and/or information relating to substance abuse treatment and/or mental health diagnoses and treatment. By signing this form, I authorize that such information to be disclosed. This information is being disclosed at my request for my own purposes. I understand that I may revoke this Authorization in writing at any time, except to the extent that WellDyne has already taken action in reliance on this Authorization. I understand that I am not required to sign this Authorization as a condition of treatment, payment, enrollment, or eligibility for benefits.

By signing below, I acknowledge that I have read and understand this Request Form.

Signature | Date

Printed Name of Personal Representative | Relationship to Patient

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