Authorization for Release of Protected Health Information

Complete this form ONLY if you want MedImpact Direct to give your health information or records, to a third party, such as a caregiver or law office.

Patient Name: _____ Member ID # (if applicable): _____

Patient Address: _____

I, or my personal representative, authorize MedImpact Direct to release my health information, my prescription history and/or any other pharmacy services I have received from MedImpact Direct, as follows:

1. My health information may be released to the following person(s) or group(s):

   Name: _____

   Address: _____

   Relationship to Patient: _____

2. Reason for Release:

   ☐ At my request (patient or personal representative) ☐ Other: _____

3. Specific Information to be Released:

   ☐ Entire Prescription History ☐ Prescription History from (date) _____ to (date) _____

   ☐ Other: _____

4. I understand that my health information may include material related to treatment of mental health conditions, alcohol or substance abuse, HIV or AIDS, or sexually transmitted diseases.

   ☐ I authorize release of this information. ☐ I **do not** authorize the release of this information.

   ☐ I authorize only the following information: _____

5. I understand that information released to a third party may no longer be protected by federal or state laws and may be released by the person or group that receives the information.
6. I understand that a photocopy of this authorization shall be considered as valid as the original.
7. I understand that authorizing the release of my health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to receive treatment, payment, enrollment or to be eligible for benefits.
8. This authorization may be canceled by my written request at any time to the address provided below. The cancellation will not apply to any information shared before that date.
9. This authorization will expire one year after your insurance plan terminates service with MedImpact Direct, unless I enter a different expiration date here: _____.
10. **For Maryland Residents Only: This authorization will expire one year after the date signed below.**

Patient Signature: _____ Date: _____

Personal Representative Signature*: _____ Date: _____
*If you are making this request on behalf of another individual, please include proof of authorized representative status.

Please return completed form to:
Address: MedImpact Direct ● Attn: Privacy Office ● PO Box 51580 ● Phoenix, AZ 85076
Email: privacy@medimpactdirect.com ● **Fax:** 888-783-1773 ● For questions, please call toll free: 855-873-8739