Authorization to Use or Disclose Protected Health Information

By completing and signing this form, I agree to allow WellDyneRx, and/or its affiliates, to discuss and/or release my protected health information (PHI) with the people or entities listed below. This form does not allow my Authorized Representative(s) to make healthcare decisions on my behalf.

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) _____

AUTHORIZED REPRESENTATIVES

The following people and/or entities have the right to receive my PHI.

FIRST NAME	LAST NAME	PHONE NUMBER	RELATIONSHIP

INFORMATION THAT CAN BE RELEASED

I allow the following information to be used or disclosed.

Check one:

☐ **All My Information** – This can include health, diagnosis (name of illness or condition), claims, doctors and other healthcare providers, and financial information (e.g. billing, banking). I understand the health 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.

☐ **Only Limited Information** may be released (check all boxes that apply to you).

- ☐ Prior Authorization Information
- ☐ Billing Information
- ☐ Eligibility and Enrollment Information
- ☐ Mail Order Prescription Information
- ☐ Retail Prescription Information
- ☐ Other: _____

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DATE YOUR AUTHORIZATION EXPIRES

I understand that I have the right to revoke this authorization at any time by providing A WRITTEN NOTICE mailed to WellDyneRx, P.O. Box 90369, Lakeland, FL 33804. I understand that a revocation is only effective after it is received and processed by WellDyneRx. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

This authorization will expire one year from the date signed unless a shorter time period is listed below.

☐ Other date or event: _____

SIGNATURE

I have read the contents of this form. I understand, agree, and allow WellDyneRx to the use or disclosure of my information. I understand that I have the right to receive a Notice of Privacy Practices upon request. I am entitled to a copy of this form. I also understand that signing this form is of my own free will. I understand that WellDyneRx does not require, and is prohibited from requiring, that I sign this form in order for me to receive treatment, enroll, or be eligible for benefits.

I understand information that is disclosed may be re-disclosed by the recipient. If this happens, it may no longer be protected under the HIPAA Privacy Rule.

_____ _____

Signature of Member or Designated Legal Representative/Guardian | Date

If this form is signed by someone other than the member or parent, 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.

_____ _____

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

_____ _____ _____ _____

Legal Representative's Street Address | City | State | Zip Code

Signature _____ Date _____

Please return the completed form by mail or fax to:
WellDyneRx
P.O. Box 90369
Lakeland, FL 33804-0369
Fax: 1-863-686-5072
Your authorization may take up to four weeks to be processed.