SERVE YOU Rx

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

All fields must be filled out.

BACKGROUND:

Name of Patient	Birthdate
Address	ID Number

By signing this form, I am authorizing Serve You Rx to use or disclose mail order pharmacy records and prescription claims information/prescription history (PBM records) as directed below.

☐ I want to authorize use and disclosure of protected health information to mail order pharmacy records only (optional).

In addition, I specifically authorize the release of records pertaining to:

☐ Mental Health
☐ HIV (AIDS)
☐ Other (Specify): _____
☐ Substance Abuse
☐ Alcohol and Drug Abuse
☐ Developmental Disabilities

The protected health information identified above may be used and disclosed to:

Name: _____

Address: _____

Specific purpose of disclosure (check all that apply): ☐ legal ☐ insurance claim ☐ disability claim
☐ college/school notification ☐ specialist consultation ☐ social security certification ☐ care giver access
☐ spouse/partner access ☐ parent/dependent access ☐ other: _____

I authorize the disclosure of information for my records dated (check one)
☐ all dates ☐ from _____ to _____.

HOW THIS FORM MAY AFFECT ME AND MY RIGHTS:

Right to Revoke Authorization. I understand that I have the right to revoke this authorization, except to the extent that **Serve You Rx** has already used or disclosed my protected health information in reliance of this authorization. I understand that my revocation is effective only if it is in writing. To revoke my authorization, I understand that I must send a written request for revocation to the **Serve You Rx** Privacy Officer at the address below.

SERVE YOU Rx

My Protected Health Information May Be Re-Disclosed. I understand that if my protected health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by a person who receives my protected health information. I understand that this re-disclosure may not be protected by the applicable privacy laws.

Right to Inspect and Copy My Protected Health Information. I understand that I have the right to inspect and copy my protected health information in **Serve You Rx** records. I understand that to inspect and copy protected health information, I must submit my request in writing to the **Serve You Rx** Privacy Officer at the address below. If I request a copy of the information, I understand that **Serve You Rx** may charge a reasonable cost-based fee in accordance with applicable law to fulfill my request. I understand that **Serve You Rx** may deny my request to inspect and copy in certain very limited circumstances. If I am denied access to protected health information, I may request that the denial be reviewed in certain circumstances.

I Am Not Required to Sign this Authorization. I understand that I may refuse to sign this authorization without affecting my ability to obtain services, care or treatment at **Serve You Rx**. However, I also acknowledge that I have agreed to sign this authorization.

Right to Receive Copy of This Authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

EXPIRATION DATE:

This authorization will remain in effect (check one)
☐ forever ☐ until the following date (or event): _____

Signature of Patient:_____ **Date:**_____

- OR -

Signature of Personal Representative: _____ **Date:**_____

If signed by a Personal Representative, complete the following:

1. The Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent* ☐ legal guardian ☐ next of kin/executor of deceased
   ☐ activated Power of Attorney (POA) for Health care

***Parent:** By signing above, I hereby declare that I have not been denied physical placement of this child nor have my parental rights been terminated by court order.

The legal authority of a legal guardian, next of kin/executor of deceased or activated Power of Attorney for health care **must be verified by providing a copy of the legal documentation to Serve You Rx**.

Please submit this completed form to:
Serve You Rx
Attn: Privacy Officer
10201 West Innovation Drive, Suite 600
Milwaukee, WI 53226