Authorization To Use and Disclose Protected Health Information

Fill out electronically, or print using blue or black ink. If you have questions or need additional forms, visit ServeYouRx.com.
One form per member. All fields must be filled out on both pages.

Mail the completed form to:
Serve You Rx
ATTN: Privacy Officer
10201 W. Innovation Drive, Suite 600
Milwaukee, WI 53226

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Gender: ☐ Male ☐ Female Member ID #: _____
Permanent Address: _____ City: _____ State: _____ ZIP: _____

AUTHORIZATIONS

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 ☐ Substance Abuse ☐ HIV (AIDS) ☐ Alcohol and Drug Abuse ☐ Developmental Disabilities
☐ Other (specify): _____

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

Last Name: _____ First Name: _____ MI: _____
Permanent Address: _____ City: _____ State: _____ ZIP: _____

Specific purpose of disclosure (check all that apply):

☐ Care giver access ☐ College/school notification ☐ Disability claim ☐ Insurance claim ☐ Legal ☐ Parent/dependent access
☐ Social security certification ☐ Specialist consultation ☐ Spouse/partner access ☐ Other (specify) _____

I authorize the disclosure of information for my records dated (check one): ☐ All dates, or ☐ 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.

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 redisclosure by a person who receives my protected health information. I understand that this redisclosure 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.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Last Name: _____ First Name: _____ MI: _____

EXPIRATION DATE

This authorization will remain in effect (check one)

☐ forever, or

☐ until the following date (or event): _____

SIGNATURE

Patient Signature: _____ Today's Date (month/day/year): _____

–OR–

Personal Representative Signature: _____ Today's Date (month/day/year): _____

If signed by a Personal Representative, complete the following:

The Individual is:

☐ A minor

☐ Legally incompetent or incapacitated

☐ Deceased

Legal authority:

☐ Parent*

☐ Legal guardian**

☐ Next of kin/executor of deceased**

☐ Activated Power of Attorney (POA) for Health care**

***By signing above, I hereby declare that I have not been denied physical placement of this child nor have my parental rights beenterminated 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.**