SERVE YOU Rx DIRECT

Prescription History Request – Mail Order

Please fill out electronically or print using blue or black ink. **One form per patient.**
If you have questions or need additional forms, visit serveyourx.com.

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), Serve You Rx 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.

Please return the completed form by:
Mail: Serve You DirectRx Pharmacy, 10201 W Innovation Dr, Suite 600, Milwaukee, WI 53226
Fax: 1-866-494-0364
Email: customerservice@serveyourx.com

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
Permanent Address: _____ City: _____ State: _____ ZIP: _____
Phone Number: _____ ☐ Mobile ☐ Work ☐ Home
Member Number (see ID card): _____ Group Number (see ID card): _____

PRESCRIPTION HISTORY DATES

From (month/day/year): _____ /_____ / _____ To (month/day/year): _____ /_____ / _____

AUTHORIZATION

☐ Fax my information to the following private fax number: _____
☐ Mail my information to:
Last Name: _____ First Name: _____
Address: _____ 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 may 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 Serve You Rx 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: _____ Today's Date (month/day/year): _____

Printed Name of Personal Representative: _____
Relationship to Patient: _____

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