MAXORplus®
PHARMACY BENEFIT MANAGEMENT SERVICES

Authorization to Use and Disclose Health Information

MEMBER / PATIENT IDENTIFICATION (please print)

Member/Patient Name:

_____
First Middle Last

Date of Birth: _____

MaxorPlus Rx Member Number: _____ Group Number: _____
(Please refer to your MaxorPlus prescription card or health benefits card)

Address: _____
Street

_____
City State Zip

Contact Phone Number: _____
(Phone number with area code where individual can be reached in case of questions)

I authorize MaxorPlus or one of its subsidiaries or affiliates to use or disclose my protected health information. I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

The following health information may be used or disclosed:

- ❑ Any information requested
- ❑ Medications list / Prescriptions
- ❑ Transaction History / Explanation of Benefits
- ❑ Benefit / Enrollment Information

Please specify reason for authorization:

- ❑ General authorization to speak on behalf
- ❑ Request for physical, printed records
- ❑ Other (please specify) _____

_____

The information identified above may be used or disclosed for the following purpose(s):

_____

_____

Please specify dates of care authorized for disclosure: _____

The health information identified above may only be disclosed to the following individual or organization: *(please complete a separate form for each authorized individual or organization)*

AUTHORIZED PARTY IDENTIFICATION (please print)

Authorized Party Name:

_____
Organization or First Middle Last

Address: _____
Street

_____
City State Zip

Relationship to Member/Patient: _____

Contact Phone Number: _____
(Phone number with area code where individual can be reached in case of questions)

We request that you provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: a) your ID number, b) your date of birth, and c) your address.

ACKNOWLEDGMENT OF AUTHORIZATION

I understand that the health information that I authorized 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.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that my refusal to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment.

I understand that I may revoke this authorization at any time provided that the information has not already been disclosed. Information that has already been disclosed may not be further disclosed by MaxorPlus once the authorization has been revoked. I understand that if I choose to revoke this authorization, I must do so in writing to the following address:

Maxor National Pharmacy Services, Attn: Privacy Compliance, 320 S. Polk St., Amarillo, TX 79101
Or Fax: (806) 324-5493 or toll free (866) 222-3274
Or Email: MaxorPlusContactUs@maxor.com

Unless otherwise revoked, this authorization will expire in five (5) years, or on the following date:

_____

NOTE TO AUTHORIZED REPRESENTATIVES: If an Authorized Representative is signing this form on behalf of the patient, additional documentation supporting the authorization to disclose patient information, such as a Power of Attorney for healthcare, must be submitted in order for records to be provided

_____ _____
Signature of patient or patient's personal representative Date

_____
Printed name of patient or patient's personal representative

If signed by patient's personal representative, please complete the following and attach supporting documentation:

Relationship to patient::_____

Authority to act for the patient::_____