Authorization to Use and Disclose Health Information

PLEASE PRINT CLEARLY

Patient's Name: ____________________ ID Number________________________

Address: __________________________ SSN: ____________________________
Street

__________________________ Date of Birth: _________/_____/________
City, State, Zip MM DD YYYY

Name of Requestor __________________ Phone Number of Requestor ______________

I authorize **Accredo Health Group** to use or disclose my health information as described below. I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and no longer protected by federal privacy regulations.

1. The following health information may be used or disclosed:

   [ ] All Patient Pharmacy & Medical Records
   [ ] All Patient Billing Records
   [ ] Date span being requested____
   [ ] Only Specific Records (please list specific type) ________________________

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

   ____

   ____

3. The health information identified above may only be disclosed to the following individual(s) or organization(s):

   Name: _________________________________

   Address:_________________________________

   ____

4. 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 and/or substance abuse.

5. 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.

6. I understand that if this authorization is for the disclosure of health information for a research study, I may refuse to sign this authorization. I understand that if I refuse to sign this authorization, I may not receive the treatment related to the research study.

7. 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 Information that has already been disclosed may not be further disclosed once the authorization has been revoked.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:

   Accredo Health Group, Inc.
   3000 Ericson Drive, Suite 100
   Warrendale, PA 15086
   FAX: 866-495-6519
   ATTN: Reimbursement Medical Records

8. I understand that I have a right to request and receive a copy of Accredo's Notice of Privacy Practices at www.Accredo.com

9. A photocopy of this authorization is as valid as the original.

10. I understand that this authorization will expire one hundred eighty (180) days from its signature date.

SIGNATURE

_______________________________________ ______________
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:_______________________________________

Prescription Claims Information is readily available for the previous ten years. A patient wanting prescription claim information sent to the address on file should call the number on the back of the prescription identification card.

Please return completed form to:

Accredo Health Group, Inc.
3000 Ericson Drive, Suite 100
Warrendale, PA 15086
FAX: 866-495-6519
ATTN: Reimbursement Medical Records

Please allow 6-8 weeks for the request to be processed.
For questions or concerns, please call toll-free 877-772-2001, ext 298819.