Authorization for Release of Information

Please read these instructions carefully before completing this form.

When to use this form

You must complete this form to authorize Prime Therapeutics to share information about you with someone else.

Note: Under the law, an authorization for use or disclosure of psychotherapy notes cannot be combined with an authorization for other health care information.

To complete this form

- Fill in the member's name, ID number and date of birth
- Fill in the name, address and phone number of the person designated to receive the information about the member
- Indicate the purpose for this authorization
- Form must be signed by one of the following:

→ Member

→ Parent or legal guardian of a minor, except† if any of the following categories of information will be released:

› Pregnancy

› Sexually transmitted disease

› Alcohol or drug abuse

› Abortion

› Hepatitis B shot

› Mental illness of a minor

†For these types of records, the minor must sign the authorization.

→ Personal representative

› Legal status documents (e.g., health care power of attorney) must be provided and accompany this authorization

Mail or fax this form to:

Prime Therapeutics LLC
Attention: Authorization Form Processing
P.O. Box 64812
St. Paul, MN 55164-0812
Fax: 877.254.3794

Authorization for Release of Information

Member Information (Person granting release of information) ***Required information**

Member name* ___________________________ Date of birth* ___________________________

Member address* ____

Member ID* ___________________________ Group number ___________________________

By signing below, I authorize the release of prescription history and other medical information about me identified below ("My Information") that is created or held by Prime Therapeutics LLC, as described in this form. My Information may include my name, address, date of birth, and plan membership status and information.

Prime Therapeutics, on behalf of my health plan, **may release My Information to:**

Name*___________________________ Phone number* ___________________________

Address*____

Email ___________________________ Fax number ___________________________

My Information that May be Released, check one or more below. *(check one or more)*

		Dates of Services From:	To:
☐ Health Plan Benefit Information:	Includes information contained in benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).	____________	____________
☐ Claims:	Includes information related to payment of your prescription claims for service you received, including pertinent information located on a claim form (i.e. billed amount, general procedure descriptions, claim payment or denial reasons, etc.).	____________	____________
☐ Coverage Determination Information:	Includes any information related to coverage decisions.	____________	____________
☐ Prescription Billing:	Includes information related to prescription charges etc.	____________	____________
☐ Services from (pharmacy or prescriber):	______________________________	Pharmacy or prescriber name: ______________________________	
☐ Other	______________________________		

My Sensitive Information That May be Released

You must initial on the line(s) below if you authorize the release of medical information, test results, records or communications regarding any of the following sensitive health information ***(note: initialing means that information may be included in the categories you designated above)***:

Initials

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome ________
- Sexually transmitted or "communicable" diseases (include hepatitis, as well as venereal diseases); ________
- Drug, alcohol or substance abuse; ________
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions); and ________
- Genetic testing. ________

Purpose for this release

☐ At the request of the member ☐ Other (please specify)________________________________

If the information relates to diagnosis or treatment of alcoholism or drug dependency, we must have the name of the treatment facilities or program(s) where the member was treated:

____

I understand that the person(s) I have named to receive the information may be required under state or federal law to treat it as confidential if it relates to the diagnosis or treatment of alcohol or drug dependency. If protected by state or federal law, the person(s) I have named to receive the information may not share alcohol or drug dependency related information without another signed authorization from me. For all other information, I understand that the information may be released by the recipient to others (if not restricted by law) and no longer protected by privacy law requirements.

Right to Revoke

I understand that I may cancel this authorization at any time by sending a written request to Prime Therapeutics at the address included in the instructions above. A Revocation of Authorization form is also available for your convenience on the Prime website. The cancellation will not apply to any information used or disclosed in reliance on the authorization. I understand that if I choose not to sign this authorization or if I cancel this authorization, it will not affect my treatment, payment, enrollment or eligibility for benefits to which I am otherwise entitled.

This authorization is valid for one (1) year after the date it is signed, unless an earlier expiration date is indicated here:

____

Signature of Member Date

X ______________________________ ______________________________

Personal Representative

If you are signing on behalf of the member, you must provide legal status documents (e.g., health care power of attorney or legal guardianship).

Signature of parent or personal representative | Relationship to Member | Date

X ______________________________ ______________________ ______________

BEFORE RETURNING THIS FORM YOU SHOULD KEEP A COPY FOR YOUR RECORD BY EITHER:
(1) MAKING A PHOTOCOPY OF THE SIGNED AUTHORIZATION; OR
(2) COMPLETING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

If you need assistance completing this form, please refer to the instructions above or contact the Customer Service number listed on the back of your Member Identification Card.