AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Member / Patient Identification (please print)

Member / Patient Name: ____
(First) (Middle) (Last)

Date of Birth: ________________ Contact Phone Number: ________________
(Month / Day / Year) *(Phone number with area code where individual can be reached in case of questions)*

Address: ____
(Street)

____
(City) (State) (Zip)

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

This document authorizes Maxor or its subsidiaries or affiliates to release certain protected health information of the member named above to the following individual or entity:

Authorized Individual / Entity: ____

Address: ____

Phone Number: ___________________________ Email address: ____________________________________

Purpose for the Release of Information: ____

Relationship to Patient / Member:

☐ Self ☐ Agent (Power of Attorney) ☐ Caregiver ☐ Healthcare Provider ☐ Insurance Carrier

☐ Legal Counsel / Attorney ☐ Other (please describe): ____

The following documents or information may be shared with the Authorized Individual/Entity listed above:

Medication/prescription history for the time period of ___/____/____ to ___/___/___

Billing/account information for the time period of ___/____/____ to ___/___/___

Other: ____________________________________ for the time period of ___/____/____ to ___/___/___

IMPORTANT: Sensitive health information or diagnoses may be included in a release of medical records. Please initial next to the following sensitive diagnoses if you permit us to release this information to the Authorized Individual/Entity:

_____HIV/AIDS _____Sexual Health _____Substance Use Disorder _____Mental illness

This authorization will remain valid until the earlier of five years from the date of signature; the occurrence of the death of the individual; the individual reaching the age of majority; permission is withdrawn; or the date entered here: _____/_____/_____.

Any information disclosed under this authorization may be subject to further disclosure by the recipient and no longer protected under state or federal protected health information law.

Maxor cannot rely upon this document to grant or authorize power of attorney decisions on your behalf. Please consult your legal representative if you require a power of attorney.

Acknowledgement of Authorization to Release Protected Health Information

I understand this authorization is voluntary and that I can refuse to sign it.

I understand that refusing to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment.

I understand I can request a copy of this authorization at any time.

I understand that I can revoke this authorization at any time in writing to the address below, unless information was already disclosed under this authorization. Information released prior to revoking this authorization will not be further disclosed.

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

Patient/ Member signature: ____ Date: ____________

Authorized Party Identification, if applicable

Authorized Representative signature: ______________________________ __________Date: ____________

Authorized Representative printed name: ____

Authorized Representative's legal authority to release patient/member information:
☐ Parent of minor patient/member ☐ Legal Guardian* ☐ Power of Attorney* ☐ Healthcare Power of Attorney*

We are committed to protecting our patient/member's privacy. Authorized representatives are asked to submit valid and active legal documentation demonstrating legal guardianship, durable power of attorney or healthcare power of attorney to support their authority to release the patient/member's protected health information, if not already on file.