

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; or
 - 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 64811
CP: 4203
St. Paul, MN 55164-0811
Fax: 800.424.3260
Email: ERxResponseTeam@primetherapeutics.com

Authorization for Release of Information

Member 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 intellectual disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions)
- Genetic testing
- Reproductive health
- Gender-affirming care

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.

Acknowledgement of Rights

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 it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

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., parent or legal guardian, health care power of attorney).

Signature of 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.