Authorization for WellDyneRx to Use and Disclose Health Information

WellDyneRx, LLC, and its affiliated entities, use this form to get your permission to discuss and/or release your protected health information (PHI) to a person or entity who is your Authorized Representative. Your approval on this form does not allow your Authorized Representative to make healthcare decisions on your behalf. If you would like a third party to help you make healthcare decisions additional documentation will be needed. If you have any questions, please contact your attorney.

PART A: MEMBER INFORMATION			
Member Last Name	Member First Name	Middle Initial	Member Date of Birth
Member Street Address	City	State	Zip Code
Daytime Phone Number (With Area Code)	Member Number (See Identification Card)	Group Number (See Identification Card)	

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION	
The following people or entities have the right to receive my information. Please check each box that applies and other information as applicable.	
□ My Spouse (Enter First and Last Name)	□ My Parents (If you are over 18-enter First and Last Name[s])
□ My Domestic Partner (Enter First and Last Name)	□ My Insurance Broker or Agent (Enter the Name of the company and First and Last Name of the Broker or Agent if you have it)
□ My Adult Children (Enter First and Last Name[s])	□ Other (Enter First and Last Name [if you have it], Name of the company, and how it is related to you)

PART C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be used or released on my behalf.

□ **All My Information**. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (Like billing and banking). I understand that the health information that I authorize 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.

OR

□ **Only limited information** may be released (Check all boxes that apply to you).

□ Prior Authorization Information
□ Billing Information
□ Retail Prescription Information
□ Mail-Order Prescription Information
□ Eligibility and Enrollment Information
□ Other: _____

PART E: DATE YOUR APPROVAL EXPIRES

I understand that I have the right to end this authorization at any time. I understand that if I want this authorization to end I must cancel this authorization IN WRITING and send my cancellation to the address listed below. I also understand that if any of my PHI has been released prior to my cancellation being received at the address listed below I cannot cancel out any action which has already happened.

I understand that this authorization will expire upon:

□ The date my health plan coverage terminates

OR

□ Earlier than described above and upon the date or event described below

_____

PART F: REVIEW AND APPROVAL

I have read the contents of this form. I understand, agree, and allow WellDyneRx to the use and release of my information as I have stated above. I understand that I have the right to receive a Notice of Privacy Practices upon request. I also understand that signing this form is of my own free will. I understand that WellDyneRx does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature	Date

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following: A copy of a health care, general or Durable Power of Attorney, or A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal Representative (Print full name)		Legal Relationship to Member	
Legal Representative's Street Address	City	State	Zip Code
Signature:			Date

Please return the completed form to:
WellDyneRx, LLC
PO Box 90369
Lakeland, FL 33804-0369
Fax 863-686-5072

Please allow 2-4 weeks for your request to be processed.