AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: ______________________

SSN: ______________ Date of Birth: ________

Address: ______________________

City: ______________________

State: ______________ Zip Code: ________

Phone: ______________________

Email: ______________________

RX Help Centers will not condition treatment, payment, or eligibility for benefits on providing or refusing to provide this authorization.

This authorizes the following medical facility or physicians: ______________________

____

to disclose information as specified below for the following purpose(s): **RX Help Centers will be acting as a prescription advocate for the patient in order to provide assistance with prescribed medications.**

____

RX Help Centers may disclose this information to:

☐ Check if same as above (disclosure to patient)

Recipient Name: ______________________

SSN: ______________ Date of Birth: ________

Address: ______________________

City: ______________________

State: ______________ Zip Code: ________

Phone: ______________________

Email: ______________________

Copies of records or medical record information within the following dates: ________ to ________

☐ Both Hospital and Medical Office Records ☐ Medical Office Records ☐ Prescription Records

☐ Records limited to a specific provider: ______________ or department: ______________

☐ X-Ray films ☐ X-Ray Digital Images ☐ Laboratory Results

NOTE: Hospital and Medical office records may include disclosure of information related to mental health, alcohol/drug, and HIV references contained within those records as part of this authorization.

The actual treatment records from mental health, or alcohol/drug departments, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below.

Mental Health department records → Signature: ______________________

Alcohol / Drug dependency treatment records → Signature: ______________________

HIV antibody test results → Signature: ______________________

Media Type: ☐ Electronic ☐ Paper **Delivery Preference:** ☐ Email/Secure Portal ☐ Mail ☐ Pickup

DURATION: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here: (date).

REVOCATION: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

REDISCLOSURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). California recipients are required to obtain your authorization before further disclosing this information.

If you are requesting a form to be completed, we may substitute a standardized version of the form that provides the same or similar information requested.

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

______________ ______________________ ______________________

Date Signature If not patient, print your name and relationship

Please submit this form via **Fax: (866) 938-6151** **Email:** billing@rxhelpcenters.com

Employee ID: ______

Employee Registration

Agent/Agency: Shared Health Alliance	Agent ID: rxc8290279	Company:

Internal Use Only

PATIENT INFORMATION

Last Name:	First Name: MI:
Address:	SS#: Birthdate:
Address 2:	Gender (circle one): ◯ Male ◯ Female
City:	Size of Household:
State: Zip:	Annual Household Income:
Email:	Insurance Carrier:
Phone:	Medicare D (circle one): ◯ Yes ◯ No
Prescriptions (name, dose, frequency, price):	Prescribing Physician (name, address, phone, fax):

By completing and submitting this form, you agree to allow an Rx Help Centers advocate to contact you regarding your prescriptions. The information that you provide will be used to determine program eligibility and will NOT be distributed to third parties. Once Rx Help Centers begins to advocate on your behalf, you can expect your brand and specialty medications to be approved in as little as 3 weeks. Generics that we assist will be approved in as little as 3 days. This processing time will vary depending on your cooperation and that of the prescribing physician.

Please initial if you understand and agree with the statement above.

I Agree __________

PATIENT CONSENT

I do ☐ do not ☐ give permission to leave information on my answering machine or voice mail.

I authorize Rx Help Centers to leave a message or discuss my information with the following people:

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

Patient Signature ______________________________ Date ____________

Please submit this form via **Fax: (866) 938-6151** **Email:** billing@rxhelpcenters.com

Representation Agreement
Prescription Drug Advocacy

In order to successfully assist our clients, Rx Help Centers requires certain permissions to act on their behalf. For that reason this document must be signed granting specific permissions which are detailed herein.

The client provides Rx Help Centers advocates the power to act on their behalf for the sole purpose of **prescription drug advocacy**. This is effective as of the date signed and will remain until the time the client no longer requires assistance from Rx Help Centers for the purpose of prescription drug advocacy. Withdrawal of these permissions will terminate the clients future prescription drug advocacy services.

Rx Help Centers will have the following powers:

- **Contact physicians on my behalf** - Rx Help Centers may contact my physician(s), discuss prescription information, and request documentation for the purpose of obtaining assistance on the client's prescription drugs.

- **Contact third parties on my behalf** - Rx Help Centers may provide information I have provided which is required information requested by a third party. This includes my financial information and any information required by the third party in order to complete the advocacy process.

- **Electronically sign on my behalf** - Rx Help Centers is authorized to digitally sign documentation on my behalf for the sole purpose of prescription drug advocacy.

By signing this document, I acknowledge all of the above conditions and information contained on this document. Any inquiries can be directed to the number listed on this document by email to billing@rxhelpcenters.com

Print Name: ______________________________

Signature: ______________________________ Date: ____________________________

P.O. Box 34555
Indianapolis, IN 46234 USA
(866) 478-9593 phone
(866) 938-6151 fax
www.rxhelpcenters.com

NOTICE OF PRIVACY RIGHTS AND PRACTICES FOR YOUR PERSONAL INFORMATION

EFFECTIVE: 1/1/2016
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Our duties and pledge to protect your personal health information ("PHI")
We are required by law to maintain the privacy of your health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information.

We are required to protect the confidentiality of your PHI and will disclose your PHI to a person other than you or your personal representative only when permitted under federal or state law. This protection extends to any PHI that is oral, written or electronic, such as information transmitted by facsimile, modem or any other electronic device. This Notice describes how we may use and disclose your PHI without your express permission. In all other circumstances, we will obtain your written authorization before we use or disclose your PHI. This Notice also describes your rights and the obligations we have regarding the use and disclosure of your PHI. Under federal and applicable state law, we are required to follow the terms of the Notice currently in effect. In some situations, state privacy or other applicable laws may provide greater privacy protections than those sated in this Notice. For example, depending on the state in which you reside, there may be additional state law privacy protections related to communicable diseases, reproductive health, substance abuse, and mental health. When appropriate, we will follow these state or other applicable laws.

HOW WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION
How We May Use and Disclose Your PHI Without Your Permission for Treatment, Payment or Healthcare Operations
Below are examples of how federal law permits use or disclosure of your PHI for these purposes without your permission:

- Treatment: PHI obtained by Rx Help Centers will be used to coordinate prescription assistance services. We may also use and disclose your PHI to your physician, other healthcare providers, drug companies or other third party sources to facilitate in this coordination.
- Payment: We may contact drug companies or other third party sources to determine your potential discount.

Other Special Circumstances
In addition to the above, we are permitted under federal and applicable state laws to use or disclose your PHI without your permission only in certain circumstances, as described below:

- Business Associates: We utilize services of other entities termed "business associates". Federal law requires us to enter into contracts with these entities to require them to safeguard your PHI and use and disclose it only as specified by us.
- Individuals involved in your care or payment for care: We may disclose your PHI to a friend, personal representatives or family member involved in your medical care or payment for your care. For example, if we can reasonably infer that you agree, we may provide information to your caregiver on your behalf.
- Disclosures to parents or legal guardians: If you are a minor, we may release your PHI to your parents or legal guardians when we are permitted or required under federal or applicable state law.

- Workers’ compensation: We may disclose your PHI to the extent authorized and necessary to comply with laws relating to workers’ compensation or similar programs established by law.
- Law enforcement: We may disclose your PHI for law enforcement purposes as required by law or in response to a court order and in certain conditions, a subpoena, warrant, summons or similar process.
- As required by law: We must disclose your PHI when required to do so by applicable federal or state law.
- Judicial and administrative proceedings: We may disclose your PHI in response to a court administrative order, and under certain conditions, subpoena, discovery request or other lawful process.
- Public health: We may disclose your PHI to federal, state or local authorities or other entities charged with preventing or controlling disease, injury or disability for public health activities. These activities may include the following: disclosures to report reactions to medications or other products to the U.S. Food and Drug Administration or other authorized entity; disclosures to notify individuals of recalls, exposure to a disease or risk for contracting or spreading a disease or condition.
- Health oversight activities: We may disclose your PHI to an oversight agency for health oversight activities authorized by law. These activities include audits, investigations, government programs, and compliance with federal and applicate state law.
- United States Department of Health and Human Services: Under federal law, we are required to disclose your PHI to the U.S. Department of Health and Human Services to determine if we are in compliance with federal laws and regulations regarding the privacy of health information.
- Coroners, medical examiners, and funeral directors: We may release your PHI to assist in identifying a deceased person or determine a cause of death.
- Administrators or executor: Upon your death, we may disclose your PHI to an administrator, executor or other similarly authorized individual under applicable state law.
- Organ or tissue procurement organizations: Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.
- To avert a serious threat to health or safety: We may use and disclose your PHI to appropriate authorities when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public.

How We May Use or Disclose Your PHI for Other Purposes Only with Your Authorization

We will obtain your written authorization before using or disclosing your PHI for purposes other than those described. You may revoke this authorization at any time by submitting a written notice to our address listed in the Contact Information below. Your revocation will not apply to information released before we receive it. You have the following rights with respect to your PHI:

- Obtain a paper copy of the Notice upon request. To obtain a copy, contact us at the address, phone number or email address listed in the Contact Information.
- Inspect and obtain a copy of your PHI. You have a right to access and copy your PHI. To inspect or obtain a copy of your PHI, submit a written request to our address listed in the Contact Information. We will respond to your request in writing within 30 days. A fee may be charged for the expense of fulfilling your request. We may deny your request in certain circumstances, such as if we have reasonably determined that providing access to PHI would endanger your life or safety or cause substantial harm to you or another person. If we deny your request, we will notify you in writing and provide you with the opportunity to request a review of the denial.

- Request an amendment of PHI: If you feel that your PHI maintained by us is incomplete or incorrect, you may request that we amend it. To request and amendment, submit a written request to our address listed in the Contact Information. Requests must identify: (i) which information you seek to amend, (ii) what corrections you would like to make, and (iii) why the information needs to be amended. We will respond to your request in writing within 60 days (with a possible 30-day extension). In our response, we will either (i) agree to make the amendment, (ii) inform you of our denial, explain our reason and outline appeal procedures. If denied, you have the right to file a statement of disagreement with the decision. We will provide a rebuttal to your statement and maintain appropriate records of your disagreement ad our rebuttal.
- Receive an accounting of disclosures of PHI. You have the right to request an accounting of disclosures of your PHI for purposes other than treatment, payment or healthcare operations. This accounting will also exclude disclosures made directly to you, made with your authorization, made to your caregivers, and certain other disclosures. To obtain an accounting, submit a written request to our address listed in the Contact Information. Requests must specify the time period, not to exceed six years. We will respond in writing within 60 days of receipt of your request (with a possible 30-day extension). We will provide one free accounting per 12-month period, but you may be charged for the cost of any subsequent accountings during the same period. We will notify you in advance of the cost involved, and you may choose to withdraw or modify your request at that time.
- Request communications of PHI by alternative means or at alternative locations. You have the right to request that we communicate with you in a certain way or at a certain location. For example, you may request that we contact you only in writing at a specific address. To request confidential communication of your PHI, submit a written request to our address listed in the Contact Information. Your request must state how, where or when you would like to be contacted. We will accommodate all reasonable requests.
- Request a restriction on certain uses and disclosures of PHI. You have the right to request a restriction or limitation on our use or disclosure of your PHI by submitting a written request to our address listed in the Contact Information.

  You must identify in this request: (i) what particular information you would like to limit, (ii) whether you want to limit use, disclosure or both, and (iii) to whom you want the limits to apply. All requests will be carefully considered, but we are not required to agree to those restrictions. We will provide you with a written response to your request within 30 days. If we do agree to restrict use or disclosure of your PHI, we will not apply these restrictions in the event of an emergency. We also have the right to terminate the restriction if (i) you agree orally or in writing or (ii) we inform you of the termination, which becomes effective only with respect to your PHI created or received after we inform you of the termination.

We will notify you promptly if a disclosure occurs in a manner that has not been detailed in this Notice if that disclosure may have compromised the privacy or security of your information.

Complaints, Questions, and Further Information

We are sincerely committed to protecting your personal privacy. We encourage you to contact us if you any questions or concerns or want further information about this Notice, our privacy practices or your privacy rights. We encourage you to contact us at the address listed in the Contact Information if you have any complaint about our privacy practices, believe that your privacy rights have been violated or have any complaint about your privacy rights. You may also file a complaint with the Office for Civil

Rights in the U.S. Department of Health and Human Services. You have our assurance that we will not retaliate in any way for your asking questions, requesting further information or filing a complaint.

Contact Information

HIPAA Privacy Officer
Rx Help Centers
P.O. Box 34555
Indianapolis, IN 46234
Toll Free Phone Number: 866.478.9593
Email Address: hipaa@rxhelpcenters.com

Changes to this Notice

This Notice of Privacy Rights and Practices is effective **1/1/2016.** We reserve the right to change our privacy practices at any time by updated this Notice on the Rx Help Centers website (www.rxhelpcenters.com). Upon request through our Contact Information, we will provide a revised Notice to you.