RxAdvance

REPRESENTATIVE APPOINTMENT AUTHORIZATION FORM

to release/disclose protected health information

Send the completed form (all pages) by fax to **508-986-7248** or by mail to
ATTN: Consumer Services, RxAdvance, 136 Turnpike Road, Southborough, MA 01772

Note: RxAdvance cannot process incomplete forms. This form must be filled out completely. Incomplete forms will be returned. If you need assistance or have any questions, please call the number on the back of your Member ID Card.

Member Information			
Member Name			
Member Health Plan Name			
Member ID #			
Member Home Address			
Member Phone #		**Member Date of Birth** (MM/DD/YYYY)	

Information Authorization	
By filling out and signing this form, I agree to the disclosure of all my health information to the recipient below. This includes medical, pharmacy, dental, vision, mental health, substance use, HIV, AIDS, psychotherapy notes, reproductive, genetic, communicable disease and health care program information. This information may include information relating to visits, admissions, treatment, claims, case management, or care coordination.	
Recipient Name Person authorized to request & receive health information	
Relation of Recipient	
Recipient Address	
Recipient Phone #	

Please fill out next page

RxAdvance

Terms of this Authorization

1. I understand that signing and giving this Authorization to RxAdvance will neither impact my enrollment or eligibility for health insurance benefits nor any treatment I am receiving or will need to receive.
2. I understand that RxAdvance will release my health information as I have directed in this Authorization. I understand that once information is released according to this Authorization, RxAdvance is no longer able to control or further safeguard any re-disclosure by the Recipient.
3. I understand that I have a right to receive a copy of this Authorization.
4. I understand that I may revoke this Authorization in writing at any time.
5. I desire this Authorization to remain in effect until _____(Please specify a date: MM/DD/YYYY). I understand that if I do not specify a date, this Authorization will remain in effect for two (2) years from the signature date on this form. **For a minor, this Authorization will expire the day before the minor's 18th birthday.**

I have read and understand the terms of this Authorization and I hereby authorize the release/disclosure of my health information in the manner described. This authorization will only be valid if it is signed by the member, a person with legal authority for a member, or the parent or legal guardian of a member that is a minor.

Signature	Printed Name	Date (MM/DD/YYYY)

If you are not the member, please indicate your relationship to the member:

☐ Parent or legal guardian of the minor member	Relationship to Minor
☐ Legally authorized person	Form of Legal Authorization (e.g. power of attorney)