RXADVANCE
136 Turnpike Rd
Southborough, MA 01772

REQUEST FOR PROTECTED HEALTH INFORMATION

Send the completed & signed form (all pages)
By mail: Privacy Officer, RxAdvance, 136 Turnpike Rd, Southborough, MA 01772
By email: privacy@rxadvance.com

Notice to Member:

- Please complete all sections and provide your most current information. RxAdvance cannot process incomplete forms. 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.
- All requests for protected health information must be submitted in writing.
- Completing this form will allow RxAdvance to share your health information with the person (including yourself) or group that you identify below.
    - Disclosure of the requested records is subject to RxAdvance approval in accordance with Federal and State laws.
- RxAdvance cannot ensure that the person or group you want to share your protected health information with will not share it with someone else.
- Once the request is approved, a copy of your PHI will be mailed to the recipient(s).
- If you are an Authorized Representative filling out the form on behalf of the member, RxAdvance will validate that your Authorized Representation status is still in effect prior to approving this request.

By filling out and signing this form, I agree to give RxAdvance permission to disclose the protected health information indicated in this form with the specified person or group.

Member Information			
Member Name		**Member Health Plan Name**	
Member Date of Birth (MM/DD/YYYY)		**Member ID**	
Member Address			
City	**State**	**Zip**	**Member Phone**

Recipient Information			
Recipient Name			
Relation of Recipient			
☐ Yourself ☐ Authorized Representative ☐ Another Person or Group			
Recipient Address			
City	**State**	**Zip**	**Recipient Phone**

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Information Requested

Please indicate what type of prescription drug details you would like to disclose. This does not include information related to Human Immunodeficiency Virus (HIV) Status, Sexually Transmitted Diseases (STDs), Behavioral Health, Substance Abuse, Contraception, and Pregnancy.

☐ Claims Records ☐ Prior Authorizations ☐ Other _____

If you would like to include information related to HIV Status, STDs, Behavioral Health, Substance Abuse, Contraception, or Pregnancy, please indicate below.

☐ HIV Status ☐ STDs ☐ Behavioral Health ☐ Substance Abuse ☐ Contraception ☐ Pregnancy

Date Range of Information Requested

Please specify the date range to include.

FROM _____ (MM/DD/YYYY) TO _____ (MM/DD/YYYY)

Termination/Expiration

Please indicate the date for the termination of this Request for Disclosure of Protected Health Information. If no date is specified, this request will expire in twelve (12) months.

Date (MM/DD/YYYY)	

Signature

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. I understand that this request does not apply to certain types of disclosures, including treatment, payment, or healthcare operations. 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.

Member/Authorized Representative Signature	Printed Name	Date (MM/DD/YYYY)