Consent for release of protected health information (PHI)

Member information (person whose information will be released)**:**

Name: _____ Date of birth: _____/ _____/ _____
First Middle Last Month Day Year

Address: _____
Street City State ZIP

Patient ID: _____ Group # (if applicable): _____ Phone #: _____
❑ Home ❑ Cell*

I understand that this authorization will allow CenterWell Pharmacy™ to use or disclose the protected health information described below:** (Please check only **one** box)

❑ Full Disclosure: Any protected health information CenterWell Pharmacy maintains, including mental health, HIV, health status or substance use or prescription records.

❑ Limited Disclosure: You specify what PHI to share. For example, limiting the information disclosed to a specific date range, prescription or class of drugs. _____

_____

This information may be disclosed to, and used by, the following person or organization (such as nursing home, care provider, and care managers) to assist me with the CenterWell Pharmacy owned products or services for which I am providing consent to disclose information:

Name: _____ Date of birth: _____/ _____/ _____
First Middle Last *Required field* Month Day Year

Or if organization: _____
Name

Address: _____
Street City State ZIP

Email: _____ Phone #: _____
❑ Home ❑ Cell*

Relationship: ❑ Spouse ❑ Sibling ❑ Parent ❑ Child ❑ Agent/Broker ❑ Friend ❑ Organization

I understand:

• I am not required to fill out this consent and CenterWell Pharmacy cannot base decisions regarding treatment or payment on whether I submit it.

• Disclosures may include information from past, present, and/or future treating providers.

• This consent is valid until I cancel my consent through my account or by submitting a written notice to CenterWell Pharmacy. For customers in the following states: CA, CT, GA, IL, MA, MD, MT, NC, NJ, NV, OH, OR, PR, VA consents will expire in compliance with applicable state laws.*** I can cancel my consent at any time by calling CenterWell Pharmacy or by submitting a written notice to CenterWell Pharmacy.

• If I cancel consent, it will not apply to any information previously released with this authorization. Once information is shared, CenterWell Pharmacy cannot prevent the person or organization who has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.

Member or Legal Representative signature _____ Date: _____ / _____ / _____
❑ Member ❑ Legal Representative

Please note: Legal representatives must attach copies of authorization as required by law. Examples include healthcare power of attorney, healthcare surrogate, living will or guardianship papers.

After you complete and sign the form, please fax it to **877-669-2844. OR** If you prefer, mail your completed form to: **CenterWell Pharmacy, P.O. Box 1056, Cincinnati, OH 45201-1056**

CenterWell Pharmacy

* By giving your cell phone number, you give CenterWell Pharmacy permission to make calls to your cell
** Health includes Medical, Dental, Pharmacy, Behavioral Health, Vision, Long-Term Care
*** Expires in 12 months: CA, CT, GA, IL, MA, MD, NC, NJ, NV, OH, OR
Expires in 24 months: MT, VA & Puerto Rico
CenterWell Pharmacy will follow the more stringent of all federal and state laws and regulations.

For CenterWell Pharmacy Use Only