MedImpact Direct®

MEDIMPACT DIRECT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth: _____

Member ID # (if applicable): _____ Relationship: _____

Patient Address: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth below:

Name and address of person or entity to whom information may be released:

_____ _____

_____ _____

_____ _____

_____ _____

Reason for disclosure: ☐ Request of individual ☐ Other: _____

Specific information to be released: ☐ Entire Prescription Record

☐ Prescription Records from (date)_____to (date) _____

Understandings:

- This authorization may be revoked in writing at any time, except to the extent that disclosure of information has already occurred prior to the receipt of revocation.
- If no expiration date, event or condition is noted, this authorization will expire one (1) year from the date of signing.
- This authorization may include disclosure of information relating to alcohol/drug abuse, mental health treatment , STD or HIV/AIDS related treatment only if I place my initial on the appropriate line below:

  _____Alcohol/Drug Treatment _____Mental Health Treatment

  _____STD Treatment _____HIV/AIDS
- I understand that a photocopy of this authorization shall be considered as effective and valid as the original.
- I understand that I am signing this authorization voluntarily and that treatment, payment, health care operations, enrollment, or eligibility for benefits may not be conditioned upon my authorization of this disclosure.

Patient Signature:_____ Date: _____

Personal Representative Signature*:_____ Date: _____

**If you are making this request on the behalf of another individual, evidence of authorized representative status must be provided to MedImpact Direct.*

Print

MedImpact Direct
Attn: Privacy Office • PO Box 51580 • Phoenix, AZ 85076 • PrivacyS@medimpact.com
Phone 855-873-8739 • Fax 888-783-1773