MEDTRAKRx

HIPAA AUTHORIZATION FORM
To Permit Disclosure of Protected Health Information

PURPOSE OF THIS FORM: This Authorization Form is to be used when an individual wishes to give another person access to his or her health information. When completed, it will allow MedTrakRx to disclose your health information to, and receive it from, the person(s) stated on the form. Please provide all information requested below, and return this form to MedTrakRx using the fax number listed on the bottom of this page.

Your Name: _____ Your Date of Birth: _____
Month / Day / Year

Your Address: _____

MedTrakRx Member ID Number: _____ Your Telephone: _____

Section 1. Please provide the name of the person(s) or organization(s) that you are authorizing to receive your Protected Health Information from MedTrakRx.

Name: _____ Date of Birth: _____

Addresses: _____

Relationship: _____ Spouse _____Child _____Parent _____Other

(If the person identified is a Power of Attorney, POA, or other legal representative who has paperwork identifying their health care and insurance decision-making abilities on your behalf, please submit a copy of that paperwork along with this completed form to MedTrakRx for review.)

Section 2. Information To Be Disclosed

Check one box to describe the health information you are authorizing to be disclosed:

☐ ALL – Check if you wish to have all your health information disclosed to the person(s) named in Section I or to MedTrakRx, or;

☐ SPECIFIC – Check if you wish to have only the following specific health information about you disclosed to the person(s) named in Section 1 or to MedTrakRx (must write in specific information):

_____

_____

_____

Section 3. Purpose of the Disclosure

Check one box to indicate the purpose of the requested disclosure of your health information:

☐ Check if the disclosure is “at the request of the individual” (or individual’s Personal Representative), or;

☐ Check if the disclosure is only for the following specific purposes (must write in the specific purposes):

_____

_____

_____

Section 4. Expiration and Revocation

Expiration: This authorization will expire as follows (complete one):

☐ On _____/_____/_____ (MM/DD/YYYY)

☐ Will expire following this event (which must relate to the Member or to the purpose of the disclosure being authorized.) _____

Right to Revoke: I understand that I may revoke all or part of this authorization at any time by giving written notice of my revocation to the Privacy Office information listed below. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before receiving my written notice of revocation.

MedTrakRx
ATTN: HIPAA Privacy Officer & Customer Service
7101 College Blvd., Suite 1000
Overland Park, KS 66210

Section 5. Signatures

I, _____ (Member Name), have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to MedTrakRx. I understand that by signing this form, I am confirming my authorization that MedTrakRx may disclose to the person or organizations named in this form the health information described in this form. I also understand that MedTrakRx will not condition payment, enrollment, or eligibility for benefits in MedTrakRx on the signing of this authorization.

I understand that once the information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws and could be re-disclosed by the person or entity that receives it.

I am entitled to keep a copy of this form for my records.

Signature – Member _____ Date _____

If this authorization is signed by a personal representative on behalf of the Member, provide a copy of the documentation to support the representation and complete the following:

Print Name of Personal Representative _____ Relationship to Member _____

Signature – Personal Representative _____ Date Signed _____