AUTHORIZATION FOR DISCLOSURE OF PERSONAL AND HEALTH INFORMATION - Prescription Assistance Program

Purpose

For you to authorize the disclosure of your personal information, which may include health information, to persons or organizations outside of the Prescription Assistance Program (PA). Your privacy is protected by state and federal privacy laws. As such, we need your explicit permission to make the requested disclosure. Please complete each section of this form.

SECTION A: Prescription Assistance Patient Information

Name: _____ Phone Number: ( ) -

Address: _____ City, State, ZIP: _____

Social Security: - - Date of Birth: - -

Specify the dates of personal representative designation. If designation is for an unlimited period, check unlimited time period. If designation is for a limited period, provide the specific dates in the space allowed. You may revoke this authorization at any time.

☐ Unlimited time period Provide specific date: _____

SECTION B: Member Signature and Effective Dates

I hereby authorize *PRESCRIPTION ASSISTANCE PROGRAM* (name of personal representative) to represent me regarding my rights and responsibilities concerning my protected health care information maintained by the Prescription Assistance Program. This includes, but is not limited to, the right to request and receive copies of my protected health information, request amendment to my health information, request restrictions, and/or authorize the release of my health information. **I understand that I may revoke all or part of this authorization at any time by giving written notice of my revocation to the Prescription Assistance Program at the address listed at the bottom of this form.**

Patient Signature: _____ Date: _____

SECTION C: Personal Representative Agreement and Signature

As the authorized personal representative of _____, I understand that I am representing the above named Prescription Assistance Program Patient and certify that the information contained herein is true to the best of my knowledge. I also certify that I will only use the above named member's health information for assisting the member with his or her health care.

Administrative Technician Signature: _____ Date: _____

Administrative Technician Name: _____ Date: _____

Director Signature: _____ Date: _____

Director Name: _____ Date: _____

Please mail this completed form and supporting documentation, if required, to the following address:

Prescription Assistance Program Office
624 Main Ave., Suite 5
Fargo, ND 58103