Authorization to Use and Disclose Protected Health Information (PHI)

Capital Rx Judi Health™

SECTION 1. WHO IS THE MEMBER?

Last Name:	First Name:		Middle Initial:
Member ID Number:	Employer/Group Name:	Date of Birth MM/DD/YYYY:	Phone Number:
Street Address:	City:	State:	Zip Code:

SECTION 2: WHO WILL DISCLOSE THE INFORMATION?

I hereby authorize the following entity or entities to use or disclose the member's protected health information (select all that apply).

☐ Capital Rx ☐ Judi Health ☐ Both

SECTION 3: WHO WILL RECEIVE THE INFORMATION?

The information may be disclosed to:

Name: (a person, a class of persons like "doctors who treated me in August 2014," or an organization)			Phone Number:
Street Address:	City:	State:	Zip Code:

SECTION 4: WHAT INFORMATION WILL BE DISCLOSED?

Please specify the type of information about your services to be disclosed, including any relevant dates if necessary.

☐ All of the member's information. This may include information about alcohol or substance use disorders, genetic information, HIV/AIDS, infectious diseases mental or behavioral health and reproductive health; OR

☐ All of the member's information EXCEPT the categories selected below. If I do not check a box all information will be disclosed.

☐ HIV/AIDS ☐ Psychiatric, Mental, or Behavioral Health Information ☐ Reproductive Health Information

☐ Substance Use Disorder (SUD) Information ☐ Genetic Information and Indicators

☐ Only the following information: _____

SECTION 5: WHAT IS THE PURPOSE OF THE DISCLOSURE?

The information is being disclosed: ☐ at my request ☐ other _____

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SECTION 6: WHAT IS THE EXPIRATION DATE OR EVENT?

I understand this authorization expires 24 months from my signature date unless I designate another event or date below or reside in a state requiring a shorter time limit. An example of an event would be when the member is no longer enrolled in the plan.

Event or date when this authorization will expire: _____

For Medicare members, this authorization is valid for one year unless: (a) a shorter time is specified above, (b) the duration of the claim, appeal, grievance, or request for which it was filed extends beyond one year, or (c) it is revoked.

SECTION 7: IMPORTANT RIGHTS AND OTHER INFORMATION YOU SHOULD KNOW

- You can revoke this authorization at any time by writing to a) Capital Rx Attn: Customer Care 9450 SW Gemini Dr., #87234, Beaverton, OR. 97008 or b) Judi Health Attn: Customer Care 9450 SW Gemini Dr. #87234 Beaverton, OR. 97008 If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- You have the right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask us for a copy at any time by writing to the applicable addresses above.
- The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- This authorization is completely voluntary, and is not required to obtain enrollment, eligibility, payment, or treatment for services.

SECTION 8: SIGNATURE

I hereby authorize the use or disclosure of protected health information about the member named above.

If you are the member, please sign here:

Member Signature	Date

If you are the member's personal representative, please sign here:

Personal Representative Signature	Date

If the member is a minor, otherwise legally incompetent, or has otherwise designated you to sign this form on the member's behalf, please describe your relationship to the member and/or your legal authority to act on the member's behalf. Please provide us with the relevant legal documents giving you this authority (e.g., a healthcare power of attorney, letters of guardianship, etc.).

Relationship/Legal Authority: _____

If you have any questions about this form, or how to fill it out, we can help. Contact the customer service number on your ID card.

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations of confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CRF Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.