Authorization to Use or Disclose Protected Health Information

By completing and signing this form, I agree to allow WellDyneRx, Inc., and/or one of its affiliates, to discuss and/or release my protected health information (PHI) with the people or entities listed below. This form does not allow my Authorized Representative(s) to make healthcare decisions on my behalf.

MEMBER INFORMATION

Last Name	First Name	Middle	Date of Birth	
Street Address		City	State	Zip Code
Phone Number	Member Number (see ID card)		Group Number (see ID card)	

AUTHORIZED REPRESENTATIVES

The following people and/or entities have the right to receive my PHI.

First Name	Last Name	Phone Number	Relationship

INFORMATION THAT CAN BE RELEASTED

I allow the following information to be used or disclosed.

Check one:

☐ **All My Information** – This can include health, diagnosis (name of illness or condition), claims, doctors and other healthcare providers, and financial information (e.g. billing, banking). I understand the health information that I authorize to be used or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health or substance abuse.

☐ **Only Limited Information** may be released (check all boxes that apply to you).

- ☐ Prior Authorization Information
- ☐ Billing Information
- ☐ Eligibility and Enrollment Information
- ☐ Mail Order Prescription Information
- ☐ Retail Prescription Information
- ☐ Other: _____

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DATE YOUR AUTHORIZATION EXPIRES

I understand that I have right to revoke this authorization at any time by providing A WRITTEN NOTICE mailed to WellDyneRx, P.O. Box 90369, Lakeland, FL 33804. I understand that a revocation is only effective after it is received and processed by WellDyneRx. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

This authorization will expire upon (check one):

☐ The date my health plan coverage terminates

☐ On this date or event: _____

SIGNATURE

I have read the contents of this form. I understand, agree, and allow WellDyneRx to the use or disclosure of my information as I have stated above. I understand that I have the right to receive a Notice of Privacy Practices upon request. I also understand that signing this form is of my own free will. I understand that WellDyneRx does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or eligibility for benefits.

I understand information that is disclosed may be re-disclosed by the recipient. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Signature of Member or Designated Legal Representative/Guardian	**Date**

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following: a copy of a health care, general or Durable Power of Attorney, or a court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Legal Representative (print full name)		Legal Relationship to Member	
Legal Representative's Street Address	City	State	Zip Code
Signature		Date	

Please return the completed form by mail or fax to:

WellDyneRx
P.O. Box 90369
Lakeland, FL 33804-0369
Fax: 1-863-686-5072

Your authorization may take up to four weeks to be processed.