PO Box 996 ATTN PBM
Portland, ME 04104
Phone: (888) 676-0257 Fax: (850) 739-7195

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act -- 45CFR Parts 160 and 164)

Please Print

Member Information: ***(Individual whose information will be released)***			
First Name	**Middle Name**	**Last Name**	
Date of Birth (MM/DD/YYYY)	**Phone Number**	**Member ID Number**	
Street Address	**City**	**State**	**Zip Code**
Parent / Legal Guardian Information: ***(If member is a minor child)***			
First Name	**Middle Name**	**Last Name**	
Date of Birth (MM/DD/YYYY)	**Phone Number**	**Member ID Number**	
Street Address	**City**	**State**	**Zip Code**

Personal Representative: (***Individual authorized to act on behalf of member***)			
First Name	**Middle Name**	**Last Name**	
Street Address	**City**	**State**	**Zip Code**
Phone Number	**Relationship to member**		

Effective Period

This authorization for release of information covers the period from:

a. ⬜ Expires upon termination of enrollment with Rightway Healthcare.

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b. ⬜ Date: ____________________ to Date: ____________________.
c. ⬜ Member or legal representative submits a written request to revoke authorization.

Authorization

I hereby authorize Rightway Healthcare to disclose the member's personally identifiable health information to the Personal Representative named above. This includes drug information, claim details, enrollment, etc. via phone or secure chat in the Rightway application.

If signing on behalf of an adult or emancipated minor, the requester attests they have the appropriate legal authority to make health care decisions on behalf of the individual, and can provide such documentation upon request. This includes, but is not limited to healthcare power of attorney, court-appointed legal guardian, or general power of attorney.

Signature of member or parent/legal guardian	**Date**

Printed Name of member or parent/legal guardian	**Relationship (if parent/legal guardian)**

Send completed form in via the Rightway app

OR

Fax completed form to (850) 739-7195

OR

Email completed form to pbmcustomercare@rightwayhealthcare.com