# Authorization for Release of Information

Please read these instructions carefully before completing this form.

**When to use this form**

You must complete this form if you want Prime Therapeutics to share information about you with someone else (e.g., an agent or family member).

Note: Under the law, an authorization for use or disclosure of psychotherapy notes cannot be combined with an authorization of other health care information.

**To complete this form**

- Fill in the member's name, ID number and date of birth
- Fill in the name, address and phone number of the person approved to receive the information
- State the purpose for this authorization unless it is at the request of the member or the member's personal representative
- Form must be signed by one of the following:
  - → Member
  - → Parent or legal guardian of a minor, except† in cases of:
    - › Pregnancy
    - › Sexually transmitted disease
    - › Alcohol or drug abuse
    - › Abortion
    - › Hepatitis B shot
    - › Mental illness of a minor

  †For these types of records, the minor must sign the authorization.

  - → Personal representative
    - › must provide legal status documents (e.g., health care power of attorney)

**Mail or fax this form to:**

Prime Therapeutics LLC
Attention: Authorization Form Processing
P.O. Box 64812
St. Paul, MN 55164-0812
**Fax:** 877.254.3794

# Authorization for Release of Information

**Member Information** (Person granting release of information) ***Required information**

Member name* _____ Date of birth* _____

Member address* _____

Member ID* _____ Group number _____

I give my permission to release prescription or other medical information about me that is created or held by Prime Therapeutics LLC. This information may include my address, date of birth, membership status, and medical claim or prescription history.

**You may release this information to:**

Name* _____ Phone number* _____

Address* _____

Email _____ Fax number _____

**Purpose for this release**

□ At the request of the member □ Other (please specify) _____

If the information relates to diagnosis or treatment of alcoholism or drug dependency, we must have the name of the treatment facilities or program(s) where the member was treated:

_____

I understand that the person(s) I have named to receive the information may be required under state or federal law to treat it as confidential if it relates to the diagnosis or treatment of alcohol or drug dependency. If protected by state or federal law, the person(s) I have named to receive the information may not share alcohol or drug dependency related information without another signed authorization from me. For all other information, I understand that the person(s) I have named may be able to release the information to others if not bound by privacy law requirements.

**Right to Revoke**

I understand that I may cancel this authorization in writing at any time. The cancellation will not apply to any information shared before that date.

This authorization is valid for only one (1) year after the date it is signed, unless an earlier expiration date is indicated here:

_____

Signature of Member Date

X _____ _____

**Personal Representative**

If you are signing on behalf of the member, you must provide legal status documents (e.g., health care power of attorney or legal guardianship).

Signature of parent or personal representative Relationship to Member Date

X _____ _____ _____