HIPAA Representative Form

I understand that by voluntarily signing this form I am authorizing and granting Elixir Rx Solutions, LLC, d/b/a Elixir, and any of its subsidiaries or affiliates (e.g., Elixir Pharmacy, etc.), permission to provide the person named below authority to access my Protected Health Information (PHI) to assist in my treatment and/or payment for that treatment. I understand that the information I authorize to disclose could be shared with other people or entities and no longer protected by federal privacy regulations. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this form.

This form is intended for Non-Medicare members. If you are enrolled in Medicare and would like to designate a representative to communicate on your behalf about a claim, prior authorization, grievance, appeal, or any other decision affecting your care or the services you receive, please complete the Appointment of Representative Form located at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf and mail to Elixir, 7835 Freedom Avenue NW, North Canton, OH 44720 (Attn: Customer Care).

Member Information:

Member Name: ___________________________ Member ID: ____________________ Date: ___________

Address: _______________________________ City, State, Zip: _________________ Phone: __________________

Authorized Individual *(Information will be disclosed to this person):*

Name: ___________________________ Date: ___________ Relationship to Member: ___________________________

Address: _______________________________ City, State, Zip: _________________ Phone: __________________

I grant to the individual named above access to (MUST CHECK ONE):

_______ All of my PHI – I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse

_______ Other: please specify limits or specific health care incident:

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I understand that this designation will (MUST CHECK ONE):

_______ Be effective for the lifetime of the member unless revoked

_______ Expire one (1) year from the date executed

I understand that I have the right to revoke this authorization, except to the extent Elixir has acted in reliance upon it, by sending written notice to: Elixir Privacy Officer, 7835 Freedom Avenue NW, North Canton, OH 44720.

Member Signature: ____________________________________ **Date:** ____________________

PLEASE SEND COMPLETED FORM TO ONE OF THE FOLLOWING:

MAIL: Elixir, 7835 Freedom Avenue NW, North Canton, OH 44720 (Attn: Customer Care)
FAX: 866-250-5178