ProCare Rx

Authorization to Use And/Or Disclose Protected Health Information (PHI)

WHY THIS FORM?

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to authorize another individual and/or entity to use and/or disclose your PHI in the Designated Record Set ("DRS") that is maintained by EHIM, Powered by ProCare Rx, or its Business Associate ("BA"). Please complete this form in its entirety so that we may provide you with the correct information you are requesting.

A. Member Information

Last Name:	First Name:	Middle Name:	
Date of Birth:	EHIM Member #:	Phone #:	
Address:	City:	State:	Zip:

B. Authorization Information

1. **Purpose.** I authorize my PHI to be used and/or disclosed for the following purpose:

☐ At the request of the Requestor ☐ Other:

2. **Description.** The following is a description of the information I authorize to be used and/or disclosed (i.e. type of record, date of record). I understand and acknowledge that only the minimum necessary PHI (determined at the discretion of EHIM, Powered by ProCare Rx) shall be disclosed, unless I specify the following:

Type of Record:	Date of Record:
Type of Record:	Date of Record:

3. **PHI Use/Disclosure.** Complete either Section A or B:

A. I hereby authorize my PHI as stated above to be disclosed by EHIM, Powered by ProCare Rx to:

Name:	Address:	Fax #:

B. I hereby authorize my PHI as stated above to be disclosed to EHIM, Powered by ProCare Rx, from:

Name: _____ Records will be sent via U.S. Mail or fax to the individual and/or entity named above.

4. **Expiration of Request.** This request will expire when I am no longer an eligible member of my current health coverage, unless I specify the following:

☐ Date: _____ OR ☐ After specific event (i.e. surgery, end of pregnancy, etc.):

5. **Revocation/Cancellation of Authorization.** I may revoke this authorization and/or cancel the disclosure at any time by completing and mailing to EHIM, Powered by ProCare Rx, its *Revocation of Authorization to Use and/or Disclose PHI* Form (call 800-311-3446 to request required form). I understand and acknowledge that revocations/cancellations of this authorization/disclosure shall not apply to information that has already been released or affect actions taken by EHIM, Powered by ProCare Rx, prior to the revocation/cancellation.

6. **Rights.** I understand and acknowledge this authorization is voluntary and I may refuse to sign this authorization. The Plan shall not condition treatment, payment, enrollment or eligibility for benefits upon receipt of this authorization.

7. **Denial of Request.** I understand and acknowledge that **MY AUTHORIZATION TO DISCLOSE MY PHI MAY BE DECLINED IF:** (1) the information I provide is not accurate; (2) this form is not completed in its entirety; and/or (3) I do not sign below. If EHIM, Powered by ProCare Rx, denies the request, it will provide me with a written explanation of the reason(s).

8. **Acknowledgement.** I have the right to authorize the use and/or disclosure of my PHI. By signing below, I hereby authorize the use and/or disclosure of my PHI as described on this form. If EHIM, Powered by ProCare Rx, accepts this request, it will abide by the disclosure from the date upon which EHIM, Powered by ProCare Rx approves the request. The information described on this form is protected by law and shall only be used and/or disclosed as indicated and shall not be re-used or re-disclosed by EHIM, Powered by ProCare Rx, without my further authorization, unless otherwise required and/or permitted by law. However, I also understand and acknowledge that the potential for the information disclosed pursuant to this authorization may be subject to re-use and/or redisclosure by the recipient and may no longer be protected by Federal privacy regulations. I understand and acknowledge this request shall not apply to information that has already been released or affect actions taken by EHIM, Powered by ProCare Rx, prior to this request. I further understand and acknowledge that EHIM, Powered by ProCare Rx, is not responsible for any action taken by any authorized recipient and/or discloser of the information released pursuant to this authorization. Finally, I understand and acknowledge that I am entitled to a copy of this request. The information described on this form is protected by law and shall only be amended as indicated above, unless otherwise required and/or permitted by law.

Signature:	Date:

If you are signing as a personal representative, complete the section below. A parent/legal guardian must sign below for a minor under the age of eighteen (18). You may be required to provide additional documentation to show that you have a legal right to request the information, unless you have completed a Designation of Personal Representative signed by the Member naming you as a personal representative. Examples of these documents include Letters of Representation or Guardianship Papers.

Signature of Personal Representative: Print Name:	Date:

Relationship: ☐ Parent/Legal Guardian ☐ Personal Representative ☐ Other

C. TO BE COMPLETED BY EHIM

☐ Request Approved. Effective Date _____ ☐ Request Denied. Reason _____

Additional Comments

EHIM Representative Signature	Date:

If you have any questions, please contact the EHIM Privacy Officer at 800-311-3446.

Please either fax this form to (248) 948-9904 or mail to:

EHIM, Powered by ProCare Rx
ATTN: Privacy Officer
26711 Northwestern Hwy, Ste 500
Southfield, MI 48033