EHIM Third Party Administration

Authorization for Disclosure of Protected Health Information (PHI)

A. Patient Information

Employee Name:	Date of Birth:	Last Four (4) Digits of SS #:	
Address:	City:	State:	Zip:
EHIM Member #:	Phone #:	Email:	

B. Release Information

I authorize EHIM, Powered by ProCare Rx, to release my health information and/or any other services I have already received, or will receive from EHIM, Powered by ProCare Rx, as follows:

1. **Description of Information to be released:**

☐ Medical from (date) ____/____/____ to (date) ____/____/____ ☐ Prescription from (date) ____/____/____ to (date) ____/____/____

☐ Other:

2. **Purpose of the Release:**

☐ At the request of Patient (or personal representative)

☐ Other:

3. **PHI Release:** The health information described above may be released to the following individual(s) or organization(s):

Name:	Relationship:		
Address:	City:	State:	Zip:
Phone #:	Email :		

4. **Expiration of Authorization:** This authorization will expire upon the termination of my current health coverage unless I specify a different date here: ____/____/____

5. **Revocation/Cancellation of Authorization:** I understand that I may cancel this authorization at any time by written request to the address listed below and such revocation shall be effective on the date of receipt by EHIM, Powered by ProCare Rx, except to the extent that EHIM, Powered by ProCare Rx, has taken action in reliance on this authorization.

6. **Notice:** I understand that the health information that I authorized to be disclosed may include information relation to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health or substance abuse.

C. Signature

I hereby authorize the disclosure of my health information by EHIM, Powered by ProCare Rx, as described on this form. 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. I understand and acknowledge that the potential for the information disclosed pursuant to this authorization may be subject to re-use and/or re-disclosure by the recipient and may no longer be protected by Federal privacy regulations. I further understand an 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.

Employee Signature:	**Date:**
Printed Name:	

If signed by a personal representative, complete the following:

Name of Personal Representative:	Relationship to Patient:		
Address:	City:	State:	Zip:
Telephone #:	Email:		
Signature of Personal Representative:		**Date:**	

Please return completed form to the address listed below, or by fax to (248) 948-9904, or by email to privacyrequests@ehimrx.com.

EHIM, Powered by ProCare Rx
ATTN: Privacy Officer – HIPAA Records Request
26711 Northwestern Highway, Ste 500
Southfield, MI 48033

For questions, please call 800-311-3446