HIPAA AUTHORIZATION TO USE AND DISCLOSE MY HEALTH INFORMATION

By signing this Authorization, I , ____(insert name)_____, DOB _____, authorize Rx Savings LLC d/b/a Rx Savings Solutions and its affiliates and subcontractors (collectively "RxSS") to use, disclose, and redisclose "My Health Information" (as described below) to the following individual:

_____	_____	_____
First Name	Last Name	Relationship to Patient

For the following purpose:

- Individual identified above can call into RxSS pharmacy support phone line on member's behalf and receive information about the services RxSS is providing to me, including my "Health Information".

My "Health Information" that will be used, disclosed and redisclosed, as described in this Authorization, includes, but is not limited to, my name, demographic (e.g. gender and date of birth), and information about my conditions, treatment, diagnoses, and medications ("My Health Information").

My Rights with Respect to this Authorization:

I understand that:

- This Authorization is voluntary. My refusal to sign this Authorization will not affect my ability to obtain treatment services from my physician practice, pharmacy or other health care providers, receive payment, enroll in a health plan, or be eligible for benefits.
- My Health Information may no longer be protected by applicable federal and state privacy laws and may be redisclosed by the person or entity who receives it.
- Unless this authorization is revoked or expired (as further detailed below), I authorize RxSS to continue using, disclosing and redisclosing My Health Information pursuant to this Authorization.
- I have the right to withdraw or revoke my Authorization at any time by contacting privacyofficer@rxss.com.
- My revocation will not be effective for uses and disclosures of My Health Information that may have occurred prior to the processing of my revocation of this Authorization.
- This Authorization will expire five (5) years after the date I sign or otherwise execute it, unless I revoke it sooner or my health plan terminates services at RxSS.
- I have the ability to obtain a copy of this Authorization by emailing privacyofficer@rxss.com.

BY AGREEING TO THIS AUTHORIZATION, I UNDERSTAND THAT MY HEALTH INFORMATION MAY BE USED AND DISCLOSED AS DESCRIBED IN THIS AUTHORIZATION.

If signed by the Patient's Legal Representative, I certify I am the Legal Representative of the individual who is the subject of this Authorization and authorized to sign this consent on behalf of that individual.

Signature: _____ Date: _____
Patient/Guardian/Representative

Print Name: _____
Patient/Guardian/Representative

If signed by someone other than the patient, indicate relationship: _____