Personal Representative Form

EmpiRx Health is committed to maintaining the privacy of your healthcare information. This form is used to give instructions to the pharmacy benefit administrator and other business associates regarding what they may or may not disclose to a particular person identified below as a member's Personal Representative. Complete this form to request a Personal Representative. A separate form must be completed for each member/dependent, if they require a Personal Representative.

MEMBER INFORMATION

FIRST NAME	LAST NAME	DATE OF BIRTH (MM/DD/YYYY)
		/ /

CARDHOLDER ID#	GROUP ID#	PHONE NUMBER
		- -

ADDRESS	CITY	STATE	ZIP CODE

REPRESENTATIVE INFORMATION

FIRST NAME _____ LAST NAME _____ RELATIONSHIP TO MEMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE NUMBER _____ DATE OF BIRTH _____

NOTE: If the Personal Representative is a court-ordered representative or has other legally designated authority, documentation must be attached, unless already provided. If a legal representative of the member, you may complete and sign this form on behalf of the member. This authorization will remain in effect until the court order or other legal designation is lifted, removed, or reversed.

TYPE OF INFORMATION

I hereby request the disclosure of my individually identifiable health information as described below by EmpiRx Health. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal and state privacy regulations. I further understand that my pharmacy prescription records may include but are not limited to identification of prescribers, as well as data regarding HIV/AIDS medications (if any) or medications for a mental health condition (if any).

☐ **DISCLOSE ALL PHI.** EmpiRx Health has my authorization to disclose PHI to my Personal Representative identified above. Disclosure includes access to information such as: drug information and claims details, enrollment, appeals, etc., via phone or via the member portal at www.empirxhealth.com. (Not all information is available online. Information available online is subject to change.)

AUTHORIZATION TIMELINE

Time Period of Representation

From: _____ To: _____

If no time period is identified, this request will remain in effect until the member or legal representative submits to EmpiRx Health a written request to change or revoke authorization.

I understand that I have the right to deny or revoke authorization at any time. A request to revoke authorization must be made in writing and submitted to EmpiRx Health at the address below. I understand that revoking authorization will not affect any decision or action that was taken or any information that has already been released based on this authorization before EmpiRx Health actually receives my request to revoke the authorization.

OVER

SIGNATURE & AUTHORIZATION

I have had full opportunity to review and consider the content of this Personal Representative Form. I confirm that this authorization is consistent with my request of the pharmacy benefit administrator. I understand that by signing this form, I am confirming my authorization that the pharmacy benefit administrator may use and/or disclose my personal health information as indicated to the person(s) identified as a Personal Representative for the purposes described on this form.

I understand that this authorization/denial is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services or covered drugs, supplies or devices, or ability to obtain treatment, covered drugs, supplies or devices.

I understand that EmpiRx Health is permitted by law, under HIPAA (Health Insurance Portability and Accessibility Act), to use and disclose my PHI without authorization for purposes of treatment, payment, and other healthcare operations.

I understand that I have a right to request and receive a Notice of Privacy Practices.

SIGNATURE OF MEMBER OR MEMBER'S REPRESENTATIVE*	DATE
PRINTED NAME OF MEMBER OR MEMBER'S REPRESENTATIVE	IF MEMBER'S REPRESENTATIVE, RELATIONSHIP

*Member's representative may sign if already given authorization by member or court order. Cannot be the same as the individual identified to be Personal Representative on this form.

MAIL COMPLETED FORM TO:

EmpiRx Health
PO Box 1339
Mechanicsburg, PA 17055

QUESTIONS

If you have any question, please contact EmpiRx Health Member Services
at the phone number on the back of your ID Card,
24 hours a day, 365 days a year.
www.empirxhealth.com