HIPAA Authorization Form

Complete this form to authorize CastiaRx to release your protected health information (PHI).

1. Provide background information

Patient Information

PATIENT NAME

DATE OF BIRTH

MEMBER ID

EMPLOYER OR PLAN SPONSOR

PHONE NUMBER

ADDRESS

CITY

STATE

ZIP

PHI Release Information

I authorize CastiaRx (or its employees, agents or representatives) to use or disclose my health information as described below. I understand that the information I authorize a person or entity to disclose may be shared with other people entities and no longer protected by federal privacy regulations.

The following health information may be used or disclosed: (please check)

- ☐ Medical expense statements
- ☐ Prescription claims information/history (PBM records)
- ☐ Mail order records
- ☐ Other: _____

The health information identified above may be used or disclosed for the following purpose(s):

The information identified above may only be disclosed to the following individual or organization:

NAME

RELATIONSHIP TO PATIENT

ADDRESS

CITY

STATE

ZIP

Form continues on back >

2. Check your work and authorize

1. I understand that the health information that I authorized to be used or disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health or substance abuse.
2. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that my refusal to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment.
3. I understand that if this authorization is for disclosure of health information for a research study, I may refuse to sign this authorization. I understand that if I refuse to sign this authorization, I may not receive the treatment related to the research study.
4. I understand that I may revoke this authorization at any time provided that the information has not already been disclosed. Information that has already been disclosed may not be further disclosed once the authorization has been revoked. I understand that if I choose to revoke this authorization, I must do so in writing to the following address:

   CastiaRx, Attn: Compliance Officer, 13660 California Street, Omaha, NE 68154
5. I understand that I can view the CastiaRx Notice of Privacy Policy at CastiaRx.com and have the right to receive a paper copy upon request. To obtain a paper copy, contact CastiaRx at 866.516.3121
6. A copy of this authorization is as valid as the original.
7. I understand that this authorization will be valid for a period of five (5) years from the date listed below unless noted otherwise:

   ☐ One Year ☐ Two Years ☐ Three Years ☐ Four Years ☐ Other

PATIENT SIGNATURE* (or patient's personal representative) _____ DATE _____

PRINTED NAME OF PATIENT* (or patient's personal representative) _____

*All dependents age 18 and over must sign this form. Information will not be released for a dependent aged 18 and over who does not sign this form.

If signed by a patient's personal representative, please complete the following and attach supporting documentation:

☐ Power of Attorney ☐ Guardianship ☐ Court Order ☐ Other

RELATIONSHIP TO PATIENT _____ AUTHORITY TO ACT FOR THE PATIENT _____

3. Submit this form

Authorization forms may be submitted by:

Email: PBM-Compliance@CastiaRx.com // **Fax**: 402.952.8072
Mail: CastiaRx, Attn: Compliance Officer, 13660 California Street, Omaha, NE 68154

Please allow 2-4 weeks for processing.