Release of Personal Information Form

I,_____, whose date of birth is_____/_____/_____, authorize
(member name) month day year
Magellan Rx Management ("MRx") to disclose my personal health information to the person(s) or entity(ies) listed below. For purposes of this authorization, my personal health information includes personal demographic information, prescription history and therapy, future prescription activity, my prescription coverage, and the status of any reimbursement for medications or copayments I have submitted to MRx. I realize that this authorization only permits the disclosure to the party(ies) listed below. The information used or disclosed in accordance with this authorization may possibly be re-distributed by the recipient, and such action is not allowed under this authorization or protected by the HIPAA Privacy Legislation. I understand that I may revoke this authorization by submitting a letter in writing stating my revocation to MRx. MRx will not condition treatment, payment, enrollment or eligibility on the authorization provided here.

This disclosure is for the purpose of: (for example, "at my request", "to facilitate judicial proceedings" etc.)

_____
(Please note: if no purpose is indicated, this authorization will be considered to be made at your request)

Disclosure may be made to:

Name(s): _____

Contact Information (if applicable): _____

_____

Please note any comments or restrictions related to this Authorization:

_____

_____

Expiration Date of Authorization: _____
(if none is listed, authorization will expire 12 months after signature date)

Member Signature:_____ Date: _____
or
Signature of Legal Representative:_____ Description of Authority: _____

Please retain a copy of this authorization for your records. If you have not retained a copy, and would like to receive a copy from Magellan Rx Management, please mark the following box. ☐

Please return Authorization to:

Magellan Rx Management
Attn: Compliance Officer
2520 Industrial Row Drive
Troy, MI 48084