integrated pharmacy services

HIPAA Authorization for the Release of Protected Health Information

Patient's Name: _____

ID Number: _____ **Date of Birth:** _____ / _____ / _____
MM DD YYYY

Street Address: _____

City, State and Zip: _____

Plan Sponsor/Employer Name: _____

I authorize LDI Integrated Pharmacy Services (or its employees, agents or representatives) ("LDI") 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 or entities and no longer protected by federal privacy regulations.

1. The following health information may be used or disclosed:

   [ ] Medical Expense Statements
   [ ] Prescription Claims Information / Prescription History (PBM records)
   [ ] Check here if only mail order records are requested
   [ ] Other _____

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

   _____
   _____

3. The health information identified above may only be disclosed to the following individual(s) or organization(s):

   Name: _____

   Address: _____

   _____

   Please State the Relationship to Patient: _____
   (e.g. Daughter, Father, Mother, Son, Spouse, etc.)

4. 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.

5. 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.

6. I understand that if this authorization is for the 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.

7. 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 Information that has already been disclosed may not be further disclosed once the authorization has been revoked.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:

   LDI Integrated Pharmacy Services
   Attn: LDI Privacy Officer
   701 Emerson Road, Suite 301
   Creve Coeur, MO 63141

8. I understand that I have a right to request and receive a copy of LDI's Notice of Privacy Practices at www.LDIRx.com

9. A photo copy of this authorization is as valid as the original.

10. **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:_____

SIGNATURE REQUIRED FOR ALL REQUESTS

_____ _____
Signature of patient or patient's personal representative Date

_____
Printed name of patient or patient's personal representative

*** Note: All dependents age 18 and over must sign this request form**. Data will not be generated for any dependent aged 18 and over who does not sign this request form.

If signed by patient's personal representative, please complete the following and attach supporting documentation [please check one]:

□ Power of Attorney □ Guardianship □ Court Order □ Other

Relationship to Patient: _____

Authority to Act for the patient: _____

Please return completed form to:
LDI Integrated Pharmacy Services
Attn: LDI Privacy Officer
701 Emerson Road, Suite 301
Creve Coeur, MO 63141
Fax: (314) 652-3126

Please allow 2 - 4 weeks for the request to be processed.
For questions or concerns, please call toll-free (866) 516-2121, ext. 6601