Representative Appointment Authorization Form

To release/disclose protected health information

Please note that RxAdvance cannot process any incomplete forms and must be filled out completely. If you need assistance, please call 800-974-5268 if you need assistance or have any questions.

Plan Name			
Member ID			
Member Name			
Home Address			
Phone #	( ) -	**Date of Birth**	/ /

Authorized information to be released/disclosed – *I hereby authorize RxAdvance to release/disclose the health information described here to the "Recipient" identified below for the purpose stated.*	
Health information to release/disclose to Recipient (*be specific, including types of information and dates*)	
Name of Recipient (*person authorized to request and receive health information*)	
Role of Recipient	
Address of Recipient	
Purpose (*please provide a specific purpose or you may state "at my request"*)	

Terms of this Authorization

1. I understand that RxAdvance will not condition my treatment, enrollment or eligibility for health insurance benefits on my signing of this Authorization.
2. I understand that RxAdvance will release my health information as directed by the terms and conditions of this Authorization. I understand that information once released according to this Authorization is out of RxAdvance's control and RxAdvance becomes unable to further safeguard such information from re-disclosure by the recipient.
3. I understand that I have a right to receive a copy of this Authorization
4. I understand that I may revoke this Authorization in writing at any time.
5. I desire this Authorization to remain in effect until ____/____/________ (please specify a date).
   I understand that if I do not specify a date, this Authorization will remain in effect for two (2) years from the signature date on this form. **For a minor, this Authorization will expire the day before the minor's 18th birthday.**

I have read and understand the terms of this Authorization and I hereby authorize the release/disclosure of my health information in the manner described above.

Signature	Date	Printed Name

This Authorization will only be valid if it is signed by the member, a person with legal authority for a member, or the parent or legal guardian of a member that is a minor. If you are not the member, please indicate your relationship to the member:

☐ Parent or legal guardian of the minor member   Relationship to minor ________

☐ Legally authorized person   Form of legal authorization (e.g. power of attorney) ________

Send completed form to:

RxAdvance, 2 Park Central Drive, ATTN: Customer Service
Southborough, MA-01772
Fax: (508) 986-7248