HIPAA Representative Form

I understand that by voluntarily signing this form I am identifying, authorizing, and granting permission to the HIPAA Representative named below to have authority to access my protected health information (PHI) to assist in my treatment and/or payment for that treatment.

Customer Information – Please Print

Customer Name:_____ Date of birth: _____

Street Address:_____ City, State, Zip Code: _____

Phone Number:_____ Member ID: _____

HIPAA Representative Information – Please Print

Name:_____ Date of birth: _____

Street Address:_____ City, State, Zip Code: _____

Phone Number:_____ Relationship to Customer: _____

I grant to the HIPAA Representative named above access to (MUST CHECK ONE):

☐ All of my PHI. I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse.

☐ Other – Specify limits or identify specific information that may be release: _____

1. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this form.
2. I understand that this designation will (MUST CHECK ONE):
   - ☐ Be effective for the lifetime of the customer unless revoked.
   - ☐ Expire one (1) year from the date executed.
3. I understand that I have the right to revoke this authorization, except to the extent Elixir Pharmacy has acted in reliance upon it.

Signature of Customer:_____ Date: _____

REVOKING THIS DESIGNATION: I understand that I may cancel this HIPAA Representation designation at any time by completing and signing the section below and returning it to: Elixir Privacy Officer, 2181 E. Aurora Rd, Twinsburg, Ohio 44087.

I no longer want:_____ to act as my Personal Representative.

Customer Signature:_____ Member ID: _____

Complete form, sign and return to: Elixir Pharmacy, 7835 Freedom Avenue NW, North Canton, Ohio 44720-6907

Administration Only: ☐ Elixir Mail Order Pharmacy ☐ Elixir Specialty Pharmacy