WithMe Health

HIPAA Authorization Form

Send the completed form (all pages) by fax to **1-866-834-4614** or by mail to:
WithMe Health, ATTN: Member Services, 204 E 2nd Ave #337 San Mateo, CA 94401

This form is used by a member to give permission for WithMe Health to disclose protected health information to a specified third party.

Individual/Member Authorizing Disclosure

Name: ______________________________ Member ID #: ___________________________

Address: ____

Telephone: ___________________________ E-mail: ______________________________

I hereby authorize WithMe Health to disclose my prescription drug history and records and any other services (collectively, "Records") as follows:

Disclosure: My Records may be disclosed to the following person(s) or entity(ies) –

Name(s): ____

Address: ____

Telephone: ___________________________ E-mail: ______________________________

Purpose: This authorization is at the request of the individual/member or his/her personal representative.

No Conditions: I understand that signing this authorization is voluntary. This authorization will not affect my ability to obtain treatment and/or health benefits or enrollment in any health plan.

Effect of Granting this Authorization: My protected health information, including my Records, may be disclosed to and/or received by persons or organizations who are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information, including my Records, and it may no longer be protected by federal health information privacy laws.

Expiration: This authorization will expire one (1) year from the date I sign the authorization below.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of revocation to the address stated on the top of this form. Revocation of this authorization will *not* affect any action taken in reliance on this authorization before receipt of my written notice of revocation.

Copies: I understand I have a right to receive a copy of this form after I sign it. A photocopy, facsimile or electronic copy of this form is as valid as the original.

Individual/Member's Signature

I, ______________________________, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, including my Records.

Signature: __________________________________ Date: __________________________

If this authorization is signed by a personal representative on behalf of the individual/member, complete the following:

Personal Representative's Name: ____

Relationship to Individual: ____