AUTHORIZATION TO RELEASE PERSONAL INFORMATION

Date: _____

To: _____

Re: (Member) _____

Plan: _____

ID#: _____

I (Member name), _____ hereby authorize MedImpact to release information about my pharmacy benefits, prior authorizations, claims, and prescription history to (printed name of individual) _____ for the purpose of (insert cause for request: i.e., medical record request, benefit determination, prior authorization, claim, or prescription history) _____.

This Authorization applies to my personal information that may be deemed as private, confidential, and protected. The purpose of this Authorization is to enable a representative, other than the pharmacy, health plan, prescribing physician, plan sponsor, or me to obtain my personal information from MedImpact for the reason(s) specified above.

This Authorization shall remain valid for one (1) year from the date indicated below. I may revoke this Authorization at any time in writing, except if MedImpact has taken action in reliance thereon or contests a claim under my policy or contests the policy itself. A photocopy or fax of this Authorization shall be considered as valid as the original.

Name: _____

Signature: _____

Date: _____

This document may contain confidential individually identifiable health information protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other statutes.