BeneCard PBF
Prescription Benefit Facilitator

Authorization for the Use and Disclosure of Individually Identifiable Health Information

PATIENT INFORMATION

FIRST NAME	LAST NAME	DATE OF BIRTH (MM/DD/YYYY)
		/ /

CARDHOLDER ID#	GROUP ID#	PHONE NUMBER
		- -

AUTHORIZATON FOR RELEASE

I hereby authorize the use or disclosure of my individually identifiable health information as described below by Benecard PBF. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. I further understand that my pharmacy prescription records may include information regarding HIV/AIDS medications (if any) or medications for a mental health conditions (if any).

1. Specific description of information that may be used or disclosed:

2. The information will be used or disclosed for the following purpose(s):

3. Person(s) or organization(s) authorized to receive the information:
   A)

   FIRST NAME LAST NAME ORGANIZATION NAME (if applicable)

   ADDRESS CITY STATE ZIP CODE

   B)

   FIRST NAME LAST NAME ORGANIZATION NAME (if applicable)

   ADDRESS CITY STATE ZIP CODE

4. Benecard PBF may impose a fee to cover cost of labor, copying, postage, and preparing a summary of the requested information. If such a fee will be imposed Benecard PBF will inform you of the fees prior to fulfilling your request. Do you agree to such fees imposed by Benecard PBF for providing a copy or summary of the requested information?

   YES_____ NO____

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services or covered drugs, supplies or devices, or ability to obtain treatment, covered drugs, supplies or devices.

OVER

6. I understand that I may revoke this authorization at any time by notifying Benecard PBF in writing, except to the extent that:
    a. action has been taken in reliance on this authorization; or
    b. if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

7. I understand that I have a right to request and receive a Notice of Privacy Practices.

This authorization expires on or upon _____ .
(Provide applicable date or event)

SIGNATURE

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE	DATE
PRINTED NAME OF PATIENT OR PATIENT'S REPRESENTATIVE	RELATIONSHIP TO PATIENT OR REPRESENTATIVE'S AUTHORITY TO ACT FOR THE PATIENT, IF APPLICABLE*

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TELEPHONE NUMBER (DURING NORMAL BUSINESS HOURS)

*Documentation required for guardianship and power of attorney. Please attach.

MAIL COMPLETED FORM TO:

BeneCard PBF
Prescription Benefit Facilitator

Benecard PBF
5040 Ritter Road
Mechanicsburg, PA 17055

QUESTIONS

If you have any question, please contact Benecard PBF Member Services at:
1-888-907-0070 TDD: 1-888-802-0020
www.benecardpbf.com