HIPAA Authorization for Use and Disclosure of Protected Health Information

1. I hereby authorize Citizens Rx LLC to use and/or disclose the protected health information about me described below ("**PHI**") to _____ _____ [INSERT NAMES(S) OF ENTITY/INDIVIDUAL].

2. The PHI that may be used and/or disclosed is: Information concerning my prescription medications and my prescription history. The PHI may be used and/or disclosed for the following purpose: _____ _____[INSERT PURPOSE].

3. This authorization shall remain in effect until: _____

4. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this form.

5. I understand that, as set forth in the notice of privacy practices, I have the right to revoke this authorization, in writing, at any time, except to the extent that Citizens Rx, LLC has acted in reliance upon it, by sending written notification to:

Citizens Rx, LLC
Attention: Privacy Officer
1144 Lake Street, 4th Floor
Oak Park, IL 60301

6. I understand that I have the right to refuse to sign this authorization.

7. I understand that PHI used or disclosed pursuant to this authorization may be redisclosed by the recipient and its confidentiality may no longer be protected by federal or state law.

_____ _____
[NAME – PLEASE PRINT] [DATE]

_____ _____
[SIGNATURE] [RELATIONSHIP TO PATIENT]

Please return: by email – dropbox@citizensrx.com; by Fax – (888) 556-7482; by mail – Privacy Officer, Citizens Rx LLC, 1144 Lake Street, 4th Floor, Oak Park IL 60301.