HIPAA - Consent and acknowledgement of receipt of privacy notice.

I understand that as part of the provision of healthcare services, MedImpact Healthcare Systems, Inc., creates and maintains health records and other information describing among other things, my prescription drug history, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

You can find a copy of the privacy notice online at https://www.elixirsolutions.com/privacy-notice.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I have provided.

By signing this form, I consent to the use and disclosure of protected health information about

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.
3. I have the right to request restrictions as to how my Protected Health Information (PHI) may be used or disclosed to carry out treatment, payment or health care operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services and auditing functions, etc.). I understand that the restrictions must be requested in writing and that the organization is not required to agree to the restrictions requested, which may have been previously agreed upon.
4. A photocopy or fax of this consent is as valid as this original.

Member Information

Member Name _____ Member ID _____

Address _____

City, State, Zip _____

Phone _____ Email _____

Signature *(or Guardian, if a minor)* _____ Date _____

Social Security Number _____

Witness Name *(optional)* _____ Witness Signature *(optional)* _____

Please send completed form to one of the following:

Mail to: MedImpact, Attn: Customer Care, 7835 Freedom Avenue NW, North Canton, OH 44720
Fax: 866-250-5178

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