The BioPlus Family of Pharmacies

HIPAA Patient Information Release Authorization Form

The following instructions explain how to complete page one of this form.
If you have any questions, please feel free to call us at the phone number on your prescription bottle.

Part A: Patient information

This section applies to the Patient who is asking for the release of their information to another person or company.

1. Print your last name, first name, and middle initial.

2. Write your date of birth in this format: mmddyyyy. (If you were born on October 5, 1960, you would write 10051960.)

3. Write your full street address, city, state, and ZIP code.

4. Write your daytime phone number, including area code.

5. Write your cell/mobile number, including area code.

The following two fields are only for Carelon members.

6. **Identification number**
   You will find this number on your member identification card.

7. **Group number**
   You will find this number on your member identification card. If your identification card does not have a group number leave this blank.

Part B: Person or company who will receive this information

8. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific by name.

9. If you check "Other," give the first and last name (if available) or the name of the company (if applicable) and how they relate to you.

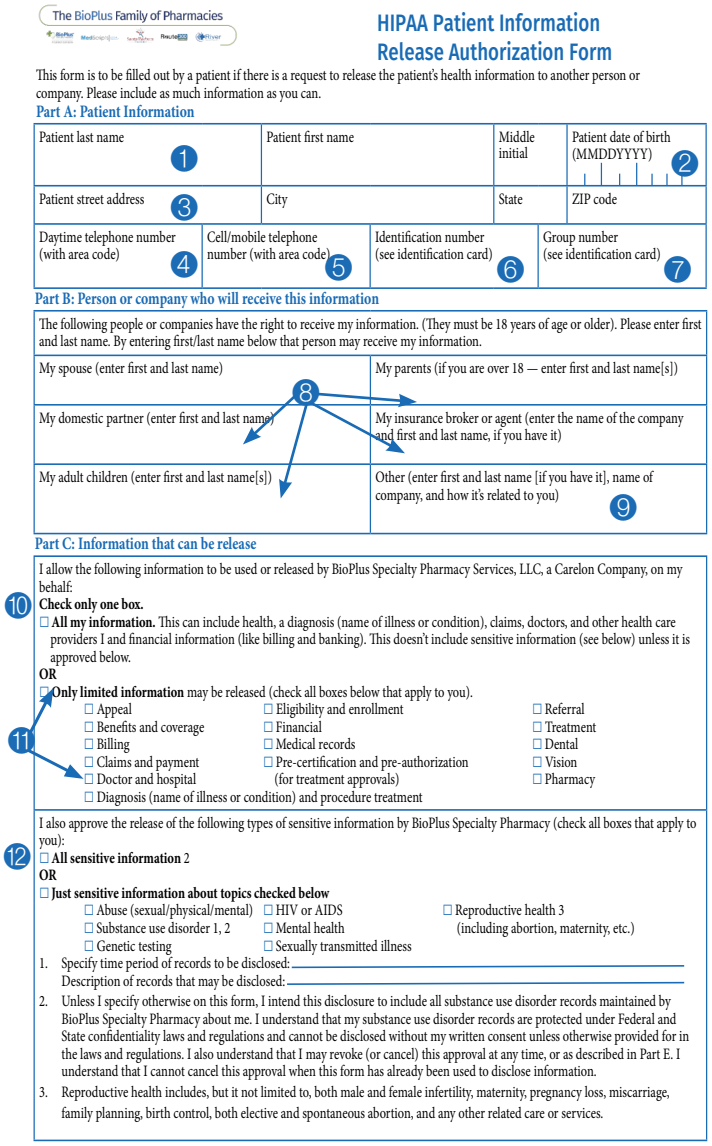
Part C: Information that can be released

This section tells us which information you would like us to release: all or just some.

10. For "all of your information," check the first box.

11. For "limited information," check the second box and the boxes that apply to you.

12. Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.



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HIPAA Patient Information Release Authorization Form

This form is to be filled out by a patient if there is a request to release the patient's health information to another person or company. Please include as much information as you can.

Part A: Patient Information

Patient last name 1	Patient first name	Middle initial	Patient date of birth (MMDDYYYY) 2
Patient street address 3	City	State	ZIP code
Daytime telephone number (with area code) 4	Cell/mobile telephone number (with area code) 5	Identification number (see identification card) 6	Group number (see identification card) 7

Part B: Person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please enter first and last name. By entering first/last name below that person may receive my information.

My spouse (enter first and last name)	My parents (if you are over 18 — enter first and last name[s])
My domestic partner (enter first and last name)	My insurance broker or agent (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name[s])	Other (enter first and last name [if you have it], name of company, and how it's related to you) 9

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Part C: Information that can be release

I allow the following information to be used or released by BioPlus Specialty Pharmacy Services, LLC, a Carelon Company, on my behalf:

10 **Check only one box.**

☐ **All my information.** This can include health, a diagnosis (name of illness or condition), claims, doctors, and other health care providers I and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ **Only limited information** may be released (check all boxes below that apply to you). 11

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Doctor and hospital
- ☐ Diagnosis (name of illness or condition) and procedure treatment
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy

I also approve the release of the following types of sensitive information by BioPlus Specialty Pharmacy (check all boxes that apply to you):

12 ☐ **All sensitive information** 2

OR

☐ **Just sensitive information about topics checked below**

- ☐ Abuse (sexual/physical/mental)
- ☐ Substance use disorder 1, 2
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Reproductive health 3 (including abortion, maternity, etc.)

1. Specify time period of records to be disclosed: _____
   Description of records that may be disclosed: _____
2. Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by BioPlus Specialty Pharmacy about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.
3. Reproductive health includes, but it not limited to, both male and female infertility, maternity, pregnancy loss, miscarriage, family planning, birth control, both elective and spontaneous abortion, and any other related care or services.

Please read the following for help completing page two of the form.

Part D: Purpose of this approval

This section tells us the reason you've asked for the release of your information.

1. Check the first box to let us know to give out this information as shown on this form.

2. Check the second box for a specific reason. An example might be to settle a life insurance claim.

Part E: Date your approval

You have two choices of when you would like this approval to end.

3. Check the first box for the standard one year that it will end.

4. Check the second box for an earlier date of less than one year, and give the date you wish this approval to end.

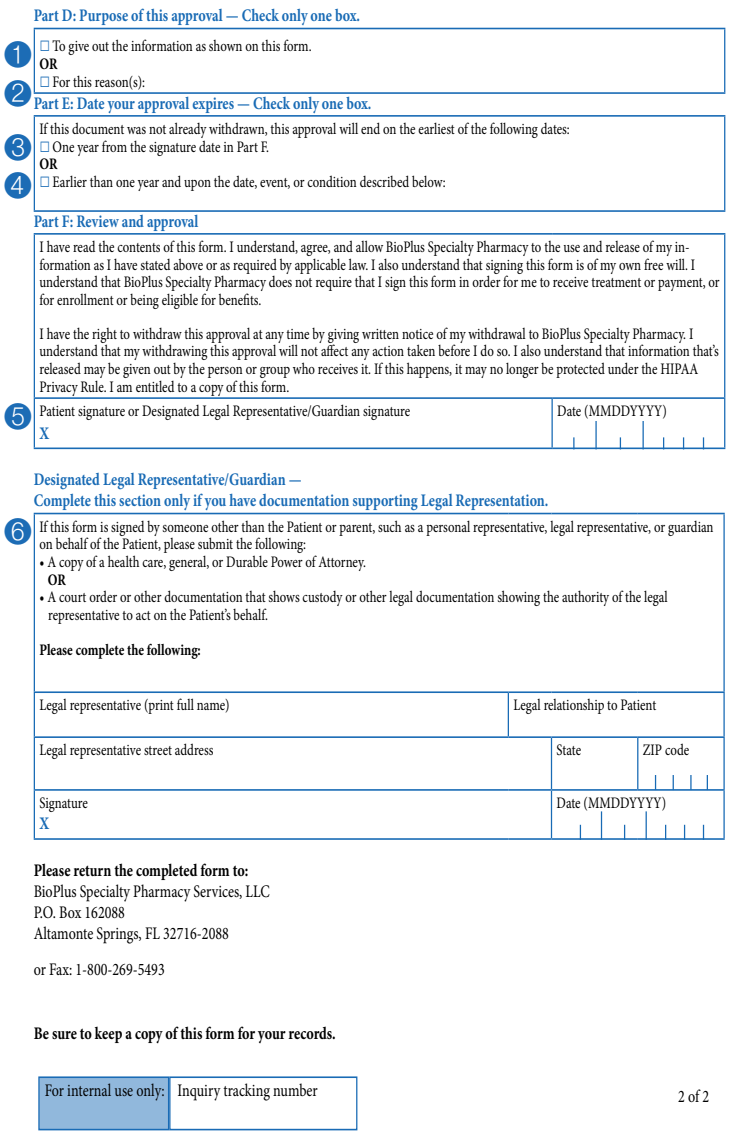
Your authorization/approval can't be granted for more than one year.

Part F: Review and approve

5. **Sign your name and put the date on the form.** Your name and signature must match the information in Part A

6. **If you are signing this form on behalf of another person, or if you have Power of Attorney for healthcare, or are a legal guardian/conservator you must do the following:**

   - You must complete the Designated Legal Representative/Guardian section.
   - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.



Part D: Purpose of this approval — Check only one box.

1 ☐ To give out the information as shown on this form.
OR
2 ☐ For this reason(s):

Part E: Date your approval expires — Check only one box.

If this document was not already withdrawn, this approval will end on the earliest of the following dates:
3 ☐ One year from the signature date in Part F.
OR
4 ☐ Earlier than one year and upon the date, event, or condition described below:

Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow BioPlus Specialty Pharmacy to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that BioPlus Specialty Pharmacy does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to BioPlus Specialty Pharmacy. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

5 Patient signature or Designated Legal Representative/Guardian signature	Date (MMDDYYYY)
X	

Designated Legal Representative/Guardian —
Complete this section only if you have documentation supporting Legal Representation.

6 If this form is signed by someone other than the Patient or parent, such as a personal representative, legal representative, or guardian on behalf of the Patient, please submit the following:
- A copy of a health care, general, or Durable Power of Attorney.
  OR
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the Patient's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to Patient	
Legal representative street address	State	ZIP code
Signature X	Date (MMDDYYYY)	

Please return the completed form to:
BioPlus Specialty Pharmacy Services, LLC
P.O. Box 162088
Altamonte Springs, FL 32716-2088

or Fax: 1-800-269-5493

Be sure to keep a copy of this form for your records.

For internal use only:	Inquiry tracking number

2 of 2

Examples of legal documents:

- **Healthcare, General, or Durable Power of Attorney.** This document gives someone you trust the legal power to act on your behalf and make healthcare decisions for you.
- **Legal Guardianship.** This is when the court appoints someone to care for another person.
- **Conservatorship.** This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for themself.
- **Executor of estate.** This type of document would be used when the person who is being represented has died.

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Part A: Patient Information

Patient last name	Patient first name	Middle initial	Patient date of birth (MMDDYYYY)
Patient street address	City	State	ZIP code

Daytime telephone number (with area code)	Cell/mobile telephone number (with area code)	Identification number (see identification card)	Group number (see identification card)

Part B: Person or company who will receive this information

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OR

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- ☐ Pharmacy

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If this form is signed by someone other than the Patient or parent, such as a personal representative, legal representative, or guardian on behalf of the Patient, please submit the following:

- A copy of a health care, general, or Durable Power of Attorney.
  OR
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the Patient's behalf.

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