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.

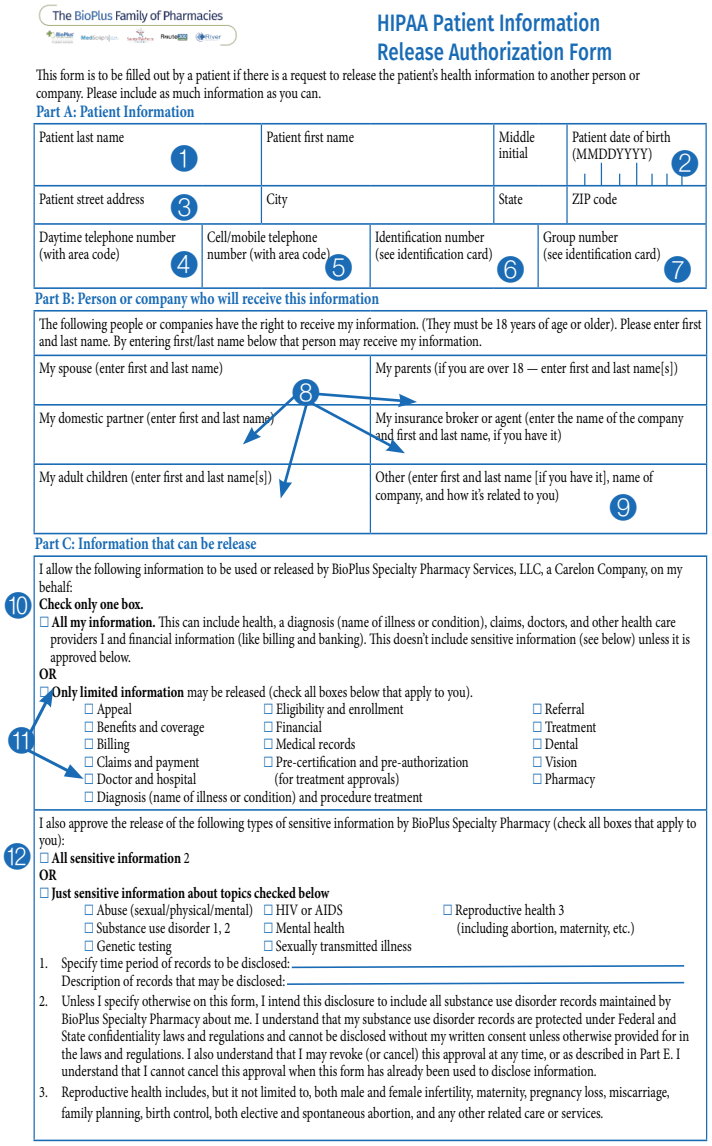
Part C: Information that can be released

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.



The BioPlus Family of Pharmacies

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.

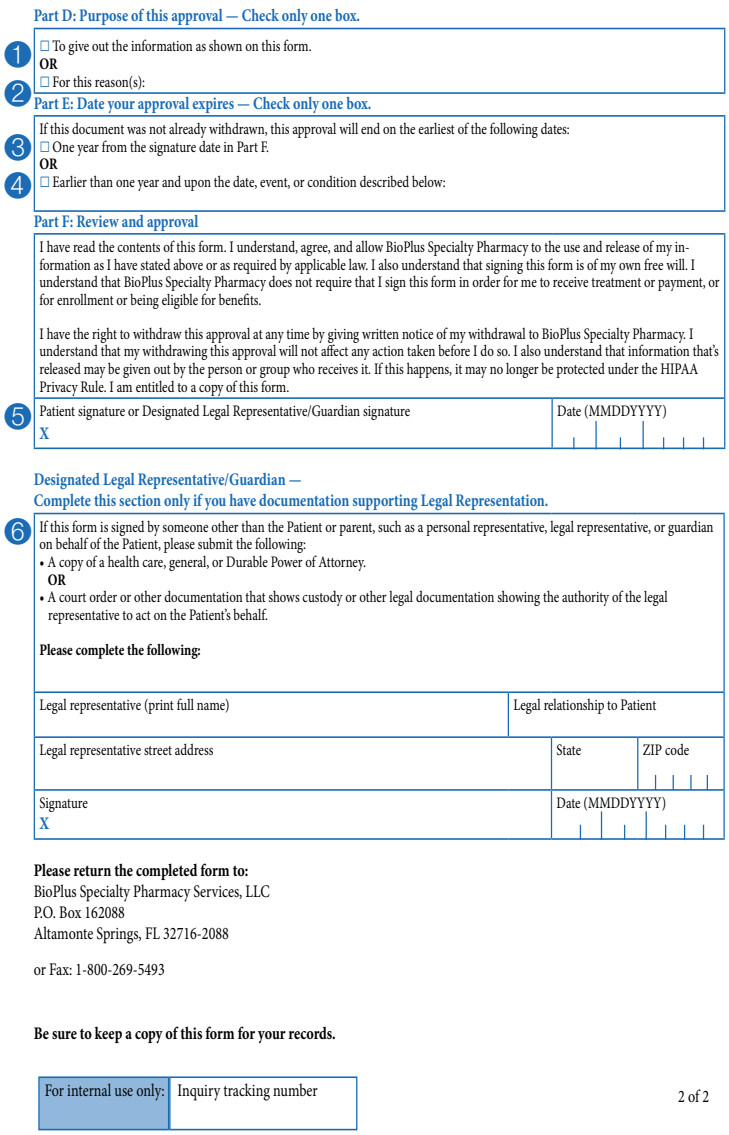
Your authorization/approval can't be granted for more than one year.

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.

The BioPlus Family of Pharmacies

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	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

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)

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:

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).

- ☐ 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):

☐ **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
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1. Specify time period of records to be disclosed: _____
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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.

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

☐ To give out the information as shown on this form.
OR
☐ 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:
☐ One year from the signature date in Part F.
OR
☐ 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.

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

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

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
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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

Get Help in Your Language

We also offer this information in a different format for members with visual impairments. If you need a different format, please call your pharmacy at the phone number on your medication label or at 1-888-292-0744 for help.

The pharmacy offers free translation and interpretation in your language for prescription use. This includes help talking with a pharmacist, understanding the prescription label, and understanding other written info. We also provide free aids like braille or large print. Contact the pharmacy to get these services quickly.

Arabic
تقدم الصيدلية الترجمة التحريرية والترجمة الشفهية الفورية مجانًا بلغتك لاستخدام الوصفة الطبية. يتضمن ذلك المساعدة في التحدث معالصيدلي وفهم ملصق الوصفة الطبية وفهم المعلومات المكتوبة الأخرى. كما نقدم مساعدات مجانية مثل طريقة برايل أو الطباعة بالأحرف ال لكبيرة. بادر بالاتصال بالصيدلية للحصول على هذه الخدمات سريعًا.

Armenian
Դեղատունն առաջարկում է անվճար բանավոր և գրավոր թարգմանություն ձեր լեզվով դեղատոմսով դեղերի մասին տեղեկությունների համար: Սա ներառում է օգնություն դեղագործի հետ խոսելու, դեղատոմսի պիտակը հասկանալու և գրավոր այլ տեղեկություններ ստանալու հարցում: Մենք տրամադրում ենք նաև անվճար օժանդակ նյութեր, ինչպիսիք են բրայլը կամ մեծատառ տպագրությունը: Այս ծառայություններն արագ ստանալու համար կապ հաստատեք դեղատան հետ:

Chinese
药房提供您语言的免费翻译和口译供处方使用。这包括帮助与药剂师交谈、了解处方标签以及了解其他书面信息。我们还提供免费辅助工具，如盲文或大字版。请联系药房以快速获得这些服务。

Farsi
داروخانه به شما خدمات ترجمه کتبی و شفاهی رایگان برای نحوه مصرف دارو ارائه می‌دهد. این خدمات عبارتند از کمک در صحبت با داروساز، درک برچسب دارو و فهمیدن سایر اطلاعات مکتوب. ما همچنین کمک‌های رایگانی مانند خط بریل یا چاپ درشت ارائه می‌دهیم. برای دریافت سریع این خدمات با داروخانه تماس بگیرید.

French
La pharmacie propose une traduction et une interprétation gratuites dans votre langue pour l'utilisation des ordonnances. Cela comprend une l’aide pour discuter avec un pharmacien, comprendre l’étiquette de prescription et d’autres informations écrites. Nous fournissons également des aides gratuites comme le braille ou les gros caractères. Contactez la pharmacie pour disposer rapidement de ces services.

Haitian- Creole
Famasi a ofri tradiksyon ak entèpretasyon gratis nan lang ou pou itilizasyon preskripsyon. Sa enkli èd pou pale ak yon famasyen, konprann etikèt preskripsyon an, ak konprann lòt enfòmasyon ekri. Nou bay èd gratis tankou bray oswa gwo lèt. Kontakte famasi a pou w jwenn sèvis sa yo byen vit.

Italian
Per i farmaci soggetti a prescrizione, la farmacia offre servizi gratuiti di traduzione e interpretariato nella tua lingua. Ciò include la comunicazione con un farmacista, la comprensione dell'etichetta dei farmaci prescritti e la comprensione di altre informazioni. scritte. Forniamo inoltre supporti gratuiti come il braille o la stampa in caratteri grandi. Contatta subito la farmacia per ottenere questi servizi.

Japanese
当薬局では、処方箋の使用に際して、お客様の言語への翻訳・通訳サービスを無料で提供しています。このサービスには、薬剤師との会話、処方箋ラベルの理解、その他の書面による情報の理解に関する支援が含まれます。また、点字や拡大文字などの補助資料も無料で提供しております。薬局にご連絡いただければ、迅速にサービスをご提供いたします。

Korean
처방전 사용을 위해 귀하의 언어로 무료 번역 및 통역 서비스를 약국에서 제공합니다. 여기에는 약사와의 상담, 처방전 라벨 이해, 기타 서면 정보 이해에 대한 지원이 포함됩니다. 점자나 대형 인쇄본과 같은 무료 보조 도구도 제공합니다. 해당 서비스를 신속하게 받으시려면 약국에 연락하시기 바랍니다.

Polish
Jeśli chcesz zrealizować receptę w swoim języku, apteka może zapewnić Ci bezpłatne tłumaczenia pisemne i ustne. Oferowana pomoc dotyczy komunikowania się z farmaceutą i zrozumienia etykiety leku oraz innych zapisanych informacji. Udostępniamy również bezpłatne pomoce, takie jak informacje zapisane alfabetem Braille'a lub dużym drukiem. Aby szybko skorzystać z tych usług, skontaktuj się z apteką.

Portuguese
A farmácia oferece tradução e interpretação gratuitas no seu idioma para uso de receitas. Isso inclui ajuda para falar com um farmacêutico, entender o rótulo da receita e entender outras informações escritas. Também fornecemos recursos gratuitos, como braille ou letras grandes. Entre em contacto com a farmácia para obter esses serviços rapidamente.

Punjabi
ਫਾਰਮੇਸੀ ਨੁਸਖ਼ੇ ਦੀ ਵਰਤੋਂ ਲਈ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫਤ ਅਨੁਵਾਦ ਅਤੇ ਵਿਆਖਿਆ ਦੀ ਪੇਸ਼ਕਸ਼ ਕਰਦੀ ਹੈ। ਇਸ ਵਿੱਚ ਇੱਕ ਫਾਰਮਾਸਿਸਟ ਨਾਲ ਗੱਲ ਕਰਨ ਵਿੱਚ ਮਦਦ, ਨੁਸਖ਼ੇ ਦੇ ਲੇਬਲ ਨੂੰ ਸਮਝਣਾ, ਅਤੇ ਹੋਰ ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣਾ ਸ਼ਾਮਲ ਹੈ। ਅਸੀਂ ਬ੍ਰੇਲ ਜਾਂ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਰਗੀਆਂ ਮੁਫ਼ਤ ਸਹਾਇਤਾ ਵੀ ਪ੍ਰਦਾਨ ਕਰਦੇ ਹਾਂ। ਇਹ ਸੇਵਾਵਾਂ ਜਲਦੀ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਫਾਰਮੇਸੀ ਨਾਲ ਸੰਪਰਕ ਕਰੋ।

Russian
Аптека предлагает бесплатный письменный и устный перевод на ваш язык для информации о рецептурных препаратах. Это включает в себя помощь в общении с фармацевтом, понимание этикетки рецепта и другую письменную информацию. Мы также предоставляем бесплатные вспомогательные материалы, такие как шрифт Брайля или крупный шрифт. Обратитесь в аптеку, чтобы получить эти услуги быстро.

Spanish
La farmacia ofrece servicios de traducción e interpretación gratuitos en su idioma para su uso con medicamentos recetados. Esto incluye ayuda para hablar con un farmacéutico, comprender la etiqueta de los medicamentos recetados y comprender otra información escrita. También ofrecemos ayuda gratuita, como braille o letra grande. Comuníquese con la farmacia para obtener estos servicios rápidamente.

Vietnamese
Nhà thuốc cung cấp bản dịch và thông dịch miễn phí bằng ngôn ngữ của quý vị cho sử dụng toa thuốc. Điều này bao gồm trợ giúp nói chuyện với dược sĩ, hiểu toa thuốc và hiểu các thông tin bằng văn bản khác. Chúng tôi cũng cung cấp các hỗ trợ miễn phí như chữ nổi braille hoặc bản in chữ lớn. Vui lòng liên hệ với nhà thuốc để nhận được những dịch vụ này một cách nhanh chóng.

Tagalog
Nag-aalok ang botika ng libreng pagsasalin at interpretasyon sa iyong lengguwahe para sa paggamit ng reseta. Kabilang dito ang tulong sa pakikipag-usap sa isang parmasyutiko, pag-unawa sa tatak ng reseta, at pag-unawa sa iba pang nakasulat na impormasyon. Nagbibigay din kami ng mga libreng tulong tulad ng braille o malaking print. Makipag-ugnayan sa parmasya upang mabilis na makuha ang mga serb.