445 Hutchinson Avenue, Suite 550, Columbus, OH 43235
614-566-0155 / 614-566-0403 fax

Request/Authorization to Release Prescription Claims Information

I, _____, do hereby give my consent for OhioHealth Group /
(Member name printed)
SignatureScripts to release prescription claims information concerning:

Member's Name _____
Cardholder Number _____
Employer Name _____

The prescriptions claims information should only include:

- ❑ The member/employee/associate claims
- ❑ The member/employee/associate & dependent claims

Please release prescription claims detail beginning ____/____/____ through ____/____/____.

The prescription claims detail will be disclosed to:

- ❑ Member
- ❑ Personal Representative, if applicable. If checked, please state relationship of Personal Representative to Member _____

The prescription claims detail should be mailed to:

_____

_____

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may revoke this authorization in writing at any time, except that the action has been taken by OhioHealth Group Service Corp./SignatureScripts by sending a written revocation to OhioHealth Group Service Corporation – Attn: HIPAA Privacy Officer, **445 Hutchinson Avenue, Suite 550, Columbus, OH 43235.**

_____
Member / Personal Representative Signature

_____
Date

_____
OHG HIPAA Privacy Officer Date

FOR INTERNAL USE ONLY

Processor: _____
Processing Date: _____

Please fax or mail the completed form to SignatureScripts for processing.