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Your Request to Share Personal Health Info

You are receiving this because you asked us to share your personal health information (PHI) with another person(s). The enclosed form will allow us to do that.

Healthcare regulations, including HIPAA, are in place to protect your PHI from others who may use it to commit identity theft, fraud, or other crimes.

What does this form do?

This form will give us permission to share your PHI with specific people you name. We will share your PHI with them if they contact us. Some examples of things we may talk to them about include medication payments, refills, or other medication-related questions.

This form does not allow them to make decisions on your behalf.

How do I give someone permission to make decisions for me?

If you want to give someone permission to make decisions on your behalf we need to have certain documents on file. This includes Power of Attorney (POA) and/or Guardianship documents.

Please send a complete, signed, and readable copy of the POA document or Letters of Guardianship to the contact information provided in this letter.

How do I complete and return this form?

Please fill out the enclosed form in full, including: name, date of birth, address, telephone number, reason for request, date, and signature.

ONLY the patient or a legally appointed representative may sign the form.

Email is the fastest way to send the form to us. But here are all the ways you can return it:

- Email: privacy@exactcarepharmacy.com
- Fax: 855-355-3480
- Mail: ExactCare Pharmacy
  Attn: Compliance Team
  8333 Rockside Road
  Valley View, OH 44125-6126

Other forms related to your privacy rights are on our website: https://exactcare.info/patient-forms

- Request to Access Records (get your records or have them sent to a third party)
- Request for Confidential Communications (alternate number/address for contact)
- Request for Amendment to PHI (request clinical records corrections)

Please call ExactCare with questions: 1-877-355-7225

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Request to Designate a Personal Representative to Have Access to Records

Section 1: Patient's Personal Information

Name: _____ DOB: _____

Address: _____ Telephone: _____

_____

I understand that upon granting access to requested records, the Company will update our records within thirty (30) days of receipt of request. This request will remain in effect for the designated individuals until such time as a Request for Restriction of Uses and Disclosure is received. Effective April 14, 2003, the Company will retain PHI records and associated documents for six (6) years from the date of last action.

Section 2: Authorization to Designate Personal Representatives to Access Your Protected Health Information

Name	Relationship/DOB	Address

*I am **AUTHORIZING** the individual(s) listed above to have access to my Protected Health Information (PHI) and they may request PHI, limited data sets or any other information or document. My signature indicates my authorization for PHI to be released to myself and/or to the designated individuals listed above.*

ONLY PATIENT MAY SIGN:

Date: _____ Signature: _____ Relationship to Individual: _____

Date: _____ Witness Signature: _____

Submit this completed request to the Company or mail to:

ExactCare Pharmacy

Todd Donnelly
8333 Rockside Rd
Valley View, OH 44125-6126

***Office Use Only* – Please Do Not Write Below This Space**

Date Request Received: _____ By: _____

❑ Notice of Approval Mailed ❑ Notice of Denial Mailed