HIPAA Authorization Form

Birdi Customer Service
1-877-668-4987 (TTY 711) or
www.BirdiRx.com

I. HIPAA Authorization for Release of Health Information

Please complete this Section if you want Birdi to disclose/release your health information to another person or entity.

I authorize **Birdi, Inc.** to disclose health information about me as described below to the individual(s) and/or entities listed below as Recipient(s).

1. **Health Information About Me That May be Disclosed:**

A. *Please check one box only*

☐ Entire Prescription History ☐ Prescription History from (date) _____ to (date) _____

☐ Other:

B. *Please initial below:*

___ I understand that the above PHI may include information related to treatment for mental health conditions, alcohol or substance use disorder, HIV or AIDS, or sexually transmitted diseases and authorize the release of this information to the Recipients named below.

2. **Individual(s) and/or Entities to whom my PHI may be Disclosed ("Recipient(s)")*:**

A. Name of Individual or Entity:_____

Address: _____

Relationship to Patient, if applicable: _____

B. Name of Individual or Entity: _____

Address: _____

Relationship to Patient, if applicable:_____

*May add additional individuals or entities on a separate page

C. **The authorized disclosures are made at my request.**

I understand that:

- once my PHI is disclosed to the Recipients listed in #2 above it may no longer be protected by federal privacy law and may be further disclosed by the Recipient(s).
- I do not need to sign this authorization in order to obtain treatment, payment for treatment, or be eligible for or enrolled in health benefits.

This letter may contain confidential individually identifiable health information protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other statutes.

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- I may cancel or revoke this authorization at any time by writing to
  Birdi, P.O. Box 8004, Novi, MI 48376-8004
  but that my cancellation will not apply to any actions taken by **Birdi** before it receives notice of my cancellation.
- This authorization expires one year after my health plan terminates service with **Birdi**, unless I enter a different expiration date here: _____.
  For Maryland Residents Only: This authorization will expire one year after the date signed below.
- I am entitled to a copy of this authorization after I sign it.

Patient Signature: _____ Date: _____
Print Patient Name: _____
Patient Address: _____
Patient Date of Birth: _____
If signed by someone other than the patient, please describe your authority to sign on behalf of the patient:
_____

II. Appointment of Representative

Please complete this Section if you wish to authorize another individual to take certain actions on your behalf related to the services provided to you by Birdi , such as ordering or refilling prescriptions.

You can only name individuals for whom you have also signed a HIPAA Authorization in Section I.

I authorize the individual listed below to perform any actions on my behalf with respect to the pharmacy services I receive from Birdi, including but not limited to:

- Order prescriptions for me
- Cancel or change my prescription orders
- Receive the status of my order
- Refill my prescriptions
- Provide information about me as needed to complete a prescription order or refill
- Other _____

Name of Individual: _____

Address: _____

Relationship to Patient:_____

I authorize Birdi to act on the directions of the above individual with respect to any pharmacy services **Birdi** provides to me.

Patient Signature: _____ Date: _____
Patient Address: _____
Print Patient Name: _____ Patient DOB: _____

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