AcariaHealth™
An envolve Pharmacy Solution

HIPAA Authorization for Use and Disclosure of Protected Health Information

Please read these instructions carefully before completing this form.

When to Use This Form

Complete this form if you want AcariaHealth, Inc. or our affiliated covered entities* to share information about you with someone else other than your current healthcare providers and insurers (example: an agent or family member). **You are not required to complete this form if you do not wish to share your Protected Health Information ("information") with others.**

How to Complete This Form

Section I: Patient Information

Provide your full name, date of birth, phone number and address.

Section 2: Purpose of the Authorization

Fill in the name of the person or organization you authorize to receive your information. You may include a brief description of the reason for sharing your information. For example, you might want to share your information with a family member to help you with your care.

Section 3: Information to be Disclosed

If you want us to share ALL information we have regarding your prescriptions, check the ALL box. If you only want us to share certain information, please specify. You **must** clearly authorize the release of information related to communicable diseases or substance abuse issues.

Section 4: Authorization Expiration

You may select a specific time period or a specific event relevant to the purpose of the disclosure. For example, you may share your information from 01/01/2017 to 12/31/2017. If you do not pick a date, your authorization will expire 12 months from the date of your signature.

Section 5: Right to Revoke your Authorization

If you wish to cancel your authorization before the expiration date, you must do so in writing. You can send a letter to **AcariaHealth, Attn: Privacy Officer, 8427 South Park Circle, Suite 400, Orlando FL 32819** or you can email Privacy@AcariaHealth.com.

Section 6: Information Regarding this Authorization

Read the information provided.

Section 7: Authorized Signature

This document is **not valid** unless you or your personal representative sign and date it. If somebody other than the patient is signing on behalf of the patient, be sure to explain the relationship to the patient and provide any documentation that verifies that person's authority.

**Affiliated covered entities include Specialty Therapeutic Care, LP, AcariaHealth Pharmacy, Inc., AcariaHealth Pharmacy #11, Inc., AcariaHealth Pharmacy #12, Inc., AcariaHealth Pharmacy #13, Inc., AcariaHealth Pharmacy #14, Inc., Homescripts.com, LLC. and Foundation Care, LLC.*

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Section 1: Patient Information

Name:_____ Date of Birth (mm/dd/yy):_____

Address:_____ Phone:_____

Section 2: Purpose of the Authorization

I authorize AcariaHealth, Inc. and any of its affiliated covered entities to disclose my protected health information, such as pharmacy services I have received from AcariaHealth, as set forth below:

You may release this information to: *(please print)*

Name:_____ Phone:_____

Address:_____

Purpose of this release *(please specify)*:_____

Section 3: Information to be Disclosed

☐ All pharmacy related records ☐ Other: *(please specify)* _____

☐ Records related to a Mental Health Condition, Alcohol or Substance abuse, HIV/AIDS, or other sexually transmitted or communicable diseases. *You must clearly authorize the release of this information by checking this box.*

Section 4: Authorization Expiration

This authorization is valid from (date):_____ to (date):_____ or will expire on the following date, event or condition: _____. If I fail to specify an expiration, **this authorization will expire in 12 months**.

Section 5: Right to Revoke your Authorization

I understand that I have the right to cancel this authorization at any time by notice in writing to the AcariaHealth Privacy Office. The cancellation will not apply to any information shared before that date.

Section 6: Information Regarding this Authorization

- I understand that this authorization is voluntary and treatment and/or payment for claims is not conditioned upon the signing of this form.
- I also understand that AcariaHealth cannot promise that the person or organization you share your health information with will not share it with someone else.
- AcariaHealth, Inc., its affiliated covered entities, employees and officers are released from any legal responsibility or liability for disclosure of the above information to the extent indicated or authorized herein.

Section 7: Authorized Signature

Signature of patient or legal representative: _____ Date: _____

If signing on behalf of patient, describe your authority/relationship to patient and provide related documentation

Printed Name: _____

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Language Assistance / Nondiscrimination Notice

Nondiscrimination Notice

AcariaHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AcariaHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AcariaHealth:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 1-800-511-5144, TTY: 711.

If you believe that AcariaHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Civil Rights Coordinator

6923 Lee Vista Blvd., Suite 300

Orlando, FL 32822

Telephone Number: 1-800-511-5144, TTY: 711

Fax: 1-877-541-1503

You can file a grievance in person or by mail, or by fax. If you need help filing a grievance, AcariaHealth is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building, Washington, D.C. 20201

Telephone Number: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-511-5144 (TTY: 711).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-511-5144 (TTY: 711).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-511-5144 (TTY：711）。

Vietnamese
CHÚ ： Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-511-5144 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-511-5144 (TTY: 711)번으로 전화해 주십시오.

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-511-5144 (TTY: 711).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-511-5144 (телетайп: 711).

Arabic
إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل ملحوظة: برقم 1-800-511-5144 (رقم هاتف الصم والبكم: 711).

French Creole
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-511-5144 (TTY: 711).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-511-5144 (ATS : 711).

Polish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-511-5144 (TTY: 711).

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-511-5144 (TTY: 711).

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-511-5144 (TTY: 711).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-511-5144 (TTY: 711).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-511-5144（TTY:711）まで、お電話にてご連絡ください。

Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-511-5144 (TTY: 711) تماس بگیرید.