



**CHRISTIAN
BROTHERS
SERVICES**

PRESCRIPTION DRUG PROGRAM

**AUTHORIZATION FORM FOR USE OR
DISCLOSURE OF PROTECTED HEALTH INFORMATION
THAT IS MAINTAINED BY THE CHRISTIAN BROTHERS
PRESCRIPTION DRUG PROGRAM**

Return completed form to CBS Prescription Drug Program via US Mail at 1205 Windham Parkway, Romeoville, IL 60446-1679 or via fax to 630-378-2505.

1. INDIVIDUAL WHOSE INFORMATION IS TO BE DISCLOSED

a. NAME AND ADDRESS

[IN MOST CASES, THIS SHOULD BE YOUR OWN NAME AND ADDRESS. IF A MINOR OR PERSONAL REPRESENTATIVE IS INVOLVED, INDICATE SUCH AND INCLUDE THEIR NAME AND ADDRESS.]

b. B. ID# (from your ID Card.): _____

2. PURPOSE OF AUTHORIZATION TO USE OR DISCLOSE

I authorize the use or disclosure of the medical information for the following purposes:

[LIST SPECIFIC PURPOSES HERE.]

3. AUTHORIZATION AND DESCRIPTION OF MEDICAL INFORMATION TO BE USED OR DISCLOSED

I authorize the Christian Brothers Services Prescription Drug Program (“CBSPDP”) to use and/or disclose the following personal medical information to the persons or entities listed in section 4 for the purposes described in section 2:

the complete medical record for services rendered on or after the following date _____.

only the following medical information:

[SPECIFICALLY DESCRIBE THE INFORMATION TO BE USED OR DISCLOSED, INCLUDING, BUT NOT LIMITED TO, MEANINGFUL DESCRIPTORS SUCH AS DATE OF SERVICE, TYPE OF SERVICE PROVIDED, LEVEL OF DETAIL TO BE RELEASED, ORIGIN OF INFORMATION, ETC.]

IMPORTANT NOTE: Unless the authorization is expressly limited, this authorization grants the CBSPDP the right to use or disclose all personal medical information for the purposes described, including medical information about any diagnosis or treatment for any mental health, substance abuse, sexually transmitted diseases (such as HIV), cancer and/or genetic condition.

4. NAME OF PERSONS TO WHOM INFORMATION MAY BE DISCLOSED

I authorize the release of the medical information described in Section 3 to the following persons or organizations:

Name: _____ Relationship _____
Name: _____ Relationship _____
Name: _____ Relationship _____

[PRINT NAME OF INDIVIDUALS OR ORGANIZATIONS TO RECEIVE INFORMATION]

5. DURATION OF AUTHORIZATION

This authorization shall be in force and effect until:

[SPECIFY (1) DATE OR (2) EVENT THAT RELATES TO THE PATIENT OR THE PURPOSE OF THE USE OR DISCLOSURE].

6. RIGHT TO REVOKE AUTHORIZATION.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

Chief Privacy Officer
Christian Brothers Services
1205 Windham Parkway
Romeoville, IL 60446-1679
cpo@cbservices.org
800-807-0100

7. ACKNOWLEDGEMENT OF PRIVACY RIGHTS

I understand that:

- a revocation is not effective to the extent that the parties named in this authorization have relied on the use or disclosure of the protected health information prior to the receipt of the revocation;
- that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law; and
- my health care provider(s) and health plan(s) may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- refuse to sign this authorization.

Signature of INDIVIDUAL REQUESTING DISCLOSURE (or Personal Representative) DATE
If Personal Representative, please include appropriate documentation.

If MINOR, Print Name of Plan Member

Description of Personal Representative's Authority, if Applicable.