



Authorization for WellDyneRx to provide access to Members Protected Health Information (PHI) to another Individual

This authorization allows WellDyneRx to give access to Members account to the named individual below. This individual will have access to all Protected Health Information (PHI) as well as have full liberty to act on the Members behalf when, for example, ordering prescriptions, refills, etc.

- The person you give access to your account will have full access to all records. PHI provided under this authorization may include application or enrollment information, claim records, claim status and patient management information, diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information.
- You may revoke this authorization at any time by notifying us in writing at the address below. The cancellation will apply from the date we receive your written notification.
- You have a right to inspect or receive a copy the PHI described above.
- Please return completed, signed authorization to the address below.

I hereby authorize WellDyneRx and any of its parent companies, subsidiaries, or other affiliates and their respective employees to disclose Protected Health Information (PHI) of the member/insured listed below to those listed in section 2.

1. Member Information

Last Name	First Name	MI
Member Phone Number	Birth date (MM/DD/YYYY)	
Street Address	City, State	Zip

2. Name of spouse/dependent

Last Name	First Name	MI
Phone Number	Birth date (MM/DD/YYYY)	
Street Address	City, State	Zip

3. Signature of Member

Signature of Member	Date
Print Name	

Mail form to: WellDyneRx
PO Box 4517
Englewood, CO 80155