PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION FOR PRIOR AUTHORIZATION OF MEDICATION

I authorize Mark Schiller, M.D. and Mind Therapy Clinic to submit my patient information to CoverMyMeds for the purpose of assisting in managing the prior authorization or other coverage determination process for prescription drugs. This information may include but is not limited to my name, date of birth, address and contact information, my medical condition, my treatment history, including prescription medications, my health insurance information, and/or financial information. This information is considered Protected Health Information ("PHI"), and is subject to local, state and federal regulations, and the HIPAA Privacy Rule, located at 45 CFR Part 160 and Subparts A and E of Part 164.

Once my PHI is submitted to CoverMyMeds, I understand that it will be used to submit coverage determinations to my health plan, and may be shared with related physician or pharmacy staff involved in my care. I understand that my information will be used only to the extent necessary to submit coverage determinations, and will not be published to those not involved in my care. However, I acknowledge that once my PHI is disclosed to third parties, it may no longer be subject to protection under the HIPAA Privacy Rule. I can review the full privacy policy at: http://www.covermymeds.com/main/privacy_policy or by writing to: Privacy Office, CoverMyMeds LL, 2 Miranova Pl., Floor 12, Columbus, Ohio 43215 or emailing to privacy@covermymeds.com

This authorization will be effective until I notify my provider that I do not want my information to be disclosed to CoverMyMeds. I understand that I can revoke this authorization at any time, that I am not required to sign this form, and that my healthcare provider cannot condition treatment or eligibility for benefits on my execution of this authorization. I understand that I have a right to receive a copy of this form.

NAME	
SIGNATURE	
DATE	
CAREGIVER	*relationship to patient and your signing rights on behalf of patient here.*

This authorization form does not form a relationship between the patient and CoverMyMeds or its customers. This form may be modified for use by healthcare providers who wish to supplement their existing consent program to ask for specific patient approval to use the CoverMyMeds service in the course of patient care. Providers should ensure that their consent program meets all applicable local, state, and federal regulations.