FAIROS
CLARITY. REDEFINED.

Protected Health Information Release Form

Completing this form gives FairosRx permission to use or disclose your protected health information, as defined by law, for the purpose stated below. Please complete the form in its entirety or the form will be considered invalid.

1 - MEMBER INFORMATION	
FULL NAME	DATE OF BIRTH
STREET ADDRESS	FAIROSRX ID NUMBER
CITY, STATE, ZIP	PHONE NUMBER WITH AREA CODE

2 - AUTHORIZED PARTY INFORMATION	
PERSON OR ORGANIZATION NAME	PHONE NUMBER
STREET ADDRESS	CITY, STATE, ZIP
RELATIONSHIP TO MEMBER	

3 – PURPOSE OF THE AUTHORIZATION

☐ At my request

☐ Other (be specific):_____

4 – INFORMATION TO BE DISCLOSED

☐ Entire record

☐ Specific date range: From _____ to _____

☐ Other: _____

Your intials are required to release the following information:

_____ HIV/AIDS Related Treatment

_____ Mental Health Treatment

_____ Drug, Alcohol or Substance Abuse Treatment

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5 – TERM OF AUTHORIZATION

☐ Authorization should expire on Month_____ Day _____ Year_____

☐ Other Event (specify): _____

NOTE: If no date or event is listed, this form will expire two years from the date of signature.

6 – YOUR RIGHTS & IMPORTANT FACTS

- I understand that the health information used or disclosed as a result of this authorization may no longer be protected by the Federal privacy standards.
- I understand that I can refuse to sign this authorization and authorizing the release of personal health information is voluntary. I understand that refusing to sign this authorization does not affect eligibility for benefits or payment for services.
- I can revoke (cancel) this authorization in writing at any time. Please mail your written cancellation to the address listed in section 7. The cancellation will not apply to any information shared before the date the cancellation is received.

7 – FORM SUBMISSION

Please submit your completed and signed form to FairosRx at the mailing address or email address below.

MAIL: 1800 S. Washington Suite 100 Amarillo, Texas 79102	**EMAIL:** Contactus@fairosrx.com

8 – MEMBER or PERSONAL REPRESENTATIVE SIGNATURE

By signing this authorization, I am affirming that to the best of my knowledge that all information provided on this form is complete, accurate and consistent with my directions. I have read the form and agree to the uses and disclosures of the information described.

Member Signature:

Printed Name:

Date:

If you are signing on behalf of the member, you must provide legal documents (e.g., health care power of attorney or legal guardianship.)

Please indicate the relationship to the individual:

☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Other:_____

Personal Representative Signature:

Printed Name:

Date: