Pequot Health Care
HIPAA Officer
1 Annie George Drive
Mashantucket, CT 06338
Phone: 888-779-6872 Fax: 860-396-6157

PEQUOTPLUS
HEALTH BENEFIT SERVICES

Due to the confidential nature of your protected health information (PHI) maintained by Pequot Health Care (Pequot Pharmaceutical Network (PRxN) and Pequot Plus Health Benefits Services) and applicable Health Insurance Portability and Accountability Act (HIPAA) regulations, all requests for any PHI must be submitted using this form to the HIPAA Officer, Pequot Health Care.

Patient Name: _____ Date of Birth: _____

Primary Cardholders SS#: _____

Card Member ID# (alternate ID): _____

I, (print name) _____, hereby authorize Pequot Health Care to release my pharmacy / medical health records information to:

Name of Recipient: _____

Address: _____
(where request is to be mailed) _____

Date request submitted: _____ Date required: _____
(allow a minimum 10 business days*)

The specific information requested consists of: *(Please include time period of requested information)*

Note: This description must be specific and meaningful.

The information will be used/disclosed for the following purposes:

This authorization is valid until revoked, in writing, and properly presented to the PHC HIPAA Officer.

I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

The authorization expires on: _____. If responding with a date, please allow Pequot Health Care adequate time to process this request and provide a response.

_____ _____
Signature of Patient/Client Date

or an authorized representative, parent or guardian if a minor, please specify relationship to patient/client. If a representative signs, please provide proof of authority to act on behalf of the patient.