



## HIPAA Authorization Form

### I. HIPAA Authorization for Release of Health Information

Please complete this Section if you want Birdi to disclose/release your health information to another person or entity. Email completed form to [complianceprivacy@birdirx.com](mailto:complianceprivacy@birdirx.com) or mail to PO Box 8004, Novi, MI 48376.

I authorize **Birdi, Inc.** to disclose health information about me as described below to the individual(s) and/or entities listed below as Recipient(s).

#### 1. Health Information About Me That May be Disclosed:

A. Please check one box only

Entire Prescription History  Prescription History from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

Other:

B. Please initial below:

\_\_\_I understand that the above PHI may include information related to treatment for mental health conditions, alcohol or substance use disorder, HIV or AIDS, or sexually transmitted diseases and authorize the release of this information to the Recipients named below.

#### 2. Individual(s) and/or Entities to whom my PHI may be Disclosed ("Recipient(s)")\*:

• Name of Individual or Entity: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Patient, if applicable: \_\_\_\_\_

• Name of Individual or Entity: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Patient, if applicable: \_\_\_\_\_

\*May add additional individuals or entities on a separate page

• **The authorized disclosures are made at my request.**

I understand that:

- Once my PHI is disclosed to the Recipients listed in #2 above it may no longer be protected by federal privacy law and may be further disclosed by the Recipient(s).
- I do not need to sign this authorization in order to obtain treatment, payment for treatment, or be eligible for or enrolled in health benefits.



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- I may cancel or revoke this authorization at any time by writing to **Birdi**, P.O. Box 8004, Novi, MI 48376 but that my cancellation will not apply to any actions taken by **Birdi** before it receives notice of my cancellation.
- This authorization expires one year after my health plan terminates service with **Birdi**, unless I enter a different expiration date here: \_\_\_\_\_.  
For Maryland Residents Only: This authorization will expire one year after the date signed below.
- I am entitled to a copy of this authorization after I sign it.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

If signed by someone other than the patient, please describe your authority to sign on behalf of the patient:

\_\_\_\_\_



## II. Appointment of Representative

Please complete this Section if you wish to authorize another individual to take certain actions on your behalf related to the services provided to you by Birdi, such as ordering or refilling prescriptions. Email completed form to [complianceprivacy@birdirx.com](mailto:complianceprivacy@birdirx.com) or mail to PO Box 8004, Novi, MI 48376.

You can only name individuals for whom you have also signed a HIPAA Authorization in Section I.

I authorize the individual listed below to perform actions on my behalf with respect to the pharmacy services I receive from **Birdi**, including but not limited to:

- Provide information about me or my treatment as needed to complete a prescription order or refill
- Order or refill my prescriptions for me
- Cancel my prescription orders
- Authorize and/or manage payment of my prescription orders
- Set or change my automated communication preferences
- Other \_\_\_\_\_

Name of Individual: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

I authorize **Birdi** to act on the directions of the above individual with respect to pharmacy services **Birdi** provides to me with respect to the above.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

For questions, visit Birdi at [www.birdirx.com](http://www.birdirx.com) or call (855) 247-3479 (TTY 711).