

- I can revoke this authorization to share my health data at any time by submitting a request in writing to:

PharmaForce PBM
 Attn: HIPAA Disclosure Coordinator
 1950 Butler Pike, STE 262
 Conshohocken, PA 19428
 Email: HIPAA@thepharmaforce.com

- If my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I do not need to give any further permission for my health information to be shared with the person(s) or organization(s) listed above.
- I do not need to sign this authorization in order to obtain treatment, payment for treatment, or be eligible for or enrolled in pharmacy benefits

 Printed name of member

 Member date of birth

 Member address

 Signature of member/legal guardian

 Date

If completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following:

 Printed name of person completing form

 Signature of person completing form

 Date

 Describe your authority to sign on behalf of the member.

E. Notarization

State of: _____

County of: _____

This instrument was acknowledged before me this _____ (date) by
 _____ (name of person signing this document).

[Seal]

 (Notary Public Signature)

 (Printed Name)

Commission Expires: _____