Navitus Health Solutions®
Authorization to Permit Disclosure of Health Information
Complete all sections for valid form

Name of Member Authorizing Release	**Navitus ID Number**
Member Address City, State, Zip	**Member Telephone**
Member SSN (Optional)	**Date of Birth**

I authorize the following disclosure of my protected health information by Navitus Health Solutions to the following individual(s):

Name Person(s): ______________________________

Address(es): ______________________________

City, State, Zip: ______________________________

1.The purpose or need for this disclosure is:

☐ Resolution of Claim Billing
☐ Insurance Eligibility and/or Benefit Information
☐ Coordinating Care for Dependent/Spouse
☐ Other (Specify):______________________________

2.The following information should be disclosed from my record:

☐ Entire record
☐ Specific drugs (specify): ________________________
☐ Specific date range (specify):____________________
☐ Other (Specify):______________________________

3.This authorization will end on the following date or event:

☐ Upon Termination of Coverage
☐ Other Event (specify): _________________________
☐ Specific date (specify):__________________________

Optional: The following sensitive information should be included in the disclosure:

☐ Alcohol/Drug Abuse Treatment
☐ Sexually Transmitted Diseases
☐ Mental Health Treatment
☐ HIV/AIDS Related Treatment
☐ Family Planning/Birth Control
☐ Other (specify): ____________________________

Your Rights With Respect to This Authorization:

- **Right to Receive Copy of This Authorization:** I understand that if I agree to sign this authorization, I can be provided with a signed copy of the form.
- **Right to Withdraw This Authorization:** I understand I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Navitus. I am aware that my withdrawal will not be effective until received by Navitus. I understand that withdrawal will not apply to uses and/or disclosures of my health information already made by Navitus.

- **Right to Refuse to Sign This Authorization:** I understand that I am under no obligation to sign this form and that Navitus may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
- **Right to Inspect or Copy the Health Information to Be Used or Disclosed:** I understand I have the right to inspect or copy the health information I have authorized to be used or disclosed by this form. I may arrange to obtain copies or inspect my health information by contacting Navitus.

Redisclosure Notification: 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 have reviewed and understand the content of this authorization. By signing this form, I confirm it accurately reflects my wishes.

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Navitus Member Signature or Signature of Legal Representative Date:

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Please Print Name
*If signed by a Legal Representative describe your authority to act for the member. Attach appropriate documentation verifying legal authority (e.g., a copy of the healthcare power of attorney form).

Please fax or mail completed authorization to:	**Navitus Health Solutions** **PO Box 999** **Appleton WI 54912-0999** **Confidential Fax: 855-668-8549**