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 hed following individual(s):	alth information by Navitus Health Solutions to the
Name Person(s):	
Address(es):	
City, State, Zip:	
1.The purpose or need for this disclosure is:☐ Resolution of Claim Billing	☐ Coordinating Care for Dependent/Spouse
☐ Insurance Eligibility and/or Benefit Information	☐ Other (Specify):
2.The following information should be disclosed from ☐ Entire record	☐ Specific date range (specify):
☐ Specific drugs (specify):	☐ Other (Specify):
3.This authorization will end on the following date or ☐ Upon Termination of Coverage ☐ Other Event (specify):	event: Specific date (specify):
Optional: The following sensitive information should ☐ Alcohol/Drug Abuse Treatment	be included in the disclosure: □ HIV/AIDS Related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health 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.

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 if my authorization cannot be fulfilled or is incomplete or unclear, additional information may be requested or the authorization may be denied. If I change my preferences, I will need to sign a new authorization.

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

Navitus Member Signature or Signature of Legal Representative	Date:
2-8	

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