

- **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:

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).

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