EpiphanyRx®
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 EpiphanyRx 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
☐ Coordinating Care for Dependent/Spouse
☐ Insurance Eligibility and/or Benefit Information
☐ Other (Specify):_____

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

☐ Entire record
☐ Specific date range (specify):_____
☐ Specific drugs (specify): _____
☐ Other (Specify):_____

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

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

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

☐ Alcohol/Drug Abuse Treatment
☐ HIV/AIDS Related Treatment
☐ Sexually Transmitted Diseases
☐ Family Planning/Birth Control
☐ Mental Health Treatment
☐ 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 EpiphanyRx. I am aware that my withdrawal will not be effective until received by EpiphanyRx. I understand that withdrawal will not apply to uses and/or disclosures of my health information already made by EpiphanyRx.

- **Right to Refuse to Sign This Authorization:** I understand that I am under no obligation to sign this form and that EpiphanyRx 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 EpiphanyRx.

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.

EpiphanyRx 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).

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