envolve
Pharmacy Solutions

Authorization to Use and Disclose Protected Health Information (PHI)

Notice to Member:

- Completing this form will allow Envolve Pharmacy Solutions to share your health information with the person or group that you identify below.
- You do not have to sign this form or give permission to share your health information. Your services and benefits with Envolve Pharmacy Solutions will not change if you do not sign this form.
- If you want to cancel or revoke this Authorization Form, it must be done in writing. Contact Envolve Pharmacy Solutions at the address at the bottom of the page and we will send you a Revocation Form.
- Envolve Pharmacy Solutions cannot promise that the person or group you want to share your health information with will not share it with someone else.
- For help filling in this form, you can contact Envolve Pharmacy Solutions Compliance Dept. at (559) 244-3700, Monday through Friday 8:30 am to 4:30 pm PST.
- When finished, mail or fax the completed, signed form to the address or fax number at the bottom of the page.

Member Information:

Member Name (print): _____

Member Date of Birth: ___/_____/_____ Member Plan ID Number: _____

Member Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) ____ - _____

I give Envolve Pharmacy Solutions permission to share my protected health information with the person or group (recipient) named below.

Recipient Information:

Name (person or group): _____

Address:

_____

City: _____ State: _____ Zip: _____ Phone: (____) ____ - _____

The purpose of the disclosure is

_____.

Envolve Pharmacy Solutions can share this Health Information: (check all boxes that apply)

- ☐ Claims/billing records
- ☐ Prescription drug information including medications prescribed, Prior Authorization status, etc.
- ☐ Benefits And services
- ☐ Other: _____

I also give permission for the following to be disclosed:

- ☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) information
- ☐ Behavioral health services or psychiatric care information

Authorization End Date or Event: _____

NOTE: If no expiration date or event is specified, the authorization will expire in **12 months.**

Member Signature: _____ **Date**: ____/____/_____

(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or court order of guardianship).

_____

Mail To: Envolve Pharmacy Solutions Attn: Compliance, 5 River Park Place East, Suite 210, Fresno CA 93720
Phone: (559) 244-3700 Fax: (844)-678-5771