envolve
Pharmacy Solutions

Revocation of Authorization to Disclose Health Information

(Keep this form and use it when you want to cancel your Authorization)

I want to cancel, or revoke, the permission I gave to Envolve Pharmacy Solutions to share my health information with this person or group:

Recipient Information:

Name (person or group): _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (_____) _____ - _____
Authorization Signed Date (if known): _____/_____/_____

Member Information:

Member Name (print): _____

Member Date of Birth: _____/_____/_____ Member Medicaid ID Number: _____

I understand that my health information may have already been shared because of the permission I gave before. I also understand that this cancellation only applies to the permission I gave to share my health information with this person or group. It does not cancel any other authorization forms I signed for health information to be shared with another person or group.

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 order of guardianship).

_____

Envolve Pharmacy Solutions will stop sharing your health information when we get this form. Use the mailing address below. You can also call for help at the number below.

Mail To: **Envolve Pharmacy Solutions** Attn: Compliance, 5 River Park Place East, Suite 210, Fresno, CA, 937120
Phone: (559) 244-3824 Fax: (855) 351-5557