HIPAA Representative Form

I understand that by voluntarily signing this form I am identifying, authorizing, and granting permission to the HIPAA Representative named below to have authority to access my protected health information (PHI) to assist in my treatment and/or payment for that treatment.

Member Information – Please Print.

Member Name: ______________________________ Date of birth: ________________

Street Address: _____________________ City, State, Zip Code: ___________________

Phone Number: ___________________________ Member ID: ____________________

HIPAA Representative Information – Please Print.

Name: ______________________________________ Date of birth: _______________

Street Address: _____________________ City, State, Zip Code: ___________________

Phone Number: ____________________ Relationship to Member: _________________

I grant to the HIPAA Representative named above access to (MUST CHECK ONE):

_______________________All of my PHI. I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse.

____________________________Other – Specify limits or identify specific information that may be release:

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1. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this form.

2. I understand that this designation will **(MUST CHECK ONE):**

_________________Be effective for the lifetime of the member unless revoked.

_________________Expire one (1) year from the date executed.

3. I understand that I have the right to revoke this authorization, except to the extent Envision has acted in reliance upon it.

Signature of Member: ______________________________Date: ______________________

REVOKING THIS DESIGNATION: I understand that I may cancel this HIPAA Representation designation at any time by completing and signing the section below and returning it to: EnvisionRx Privacy Officer, 2181 E. Aurora Rd, Twinsburg, OH 44087.

I no longer want: ____to act as my Personal Representative.

Member Signature: ____________________________Member ID: ________________