

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:

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: _____

Complete form, sign and return to: EnvisionPharmacies, 7835 Freedom Avenue NW, North Canton, Ohio 44720-6907

Administration Only: EnvisionMail EnvisionSpecialty EnvisionCompounding