Authorization for Novixus Pharmacy Services to provide access to Member's Protected Health Information (PHI) to another Individual

This authorization allows Novixus Pharmacy Services to give access to Member's account to the named individual below. This individual will have access to all Protected Health Information (PHI) as well as have full liberty to act on the Member's behalf when, for example, ordering prescriptions, refills, etc.

- The person you give access to your account will have full access to all records. PHI provided under this authorization may include application or enrollment information, claim records, claim status and patient management information, diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information.

- You may revoke this authorization at any time by notifying us in writing at the address below. The cancellation will apply from the date we receive your written notification.
- You have the right to inspect or receive a copy of the PHI described above.
- Please return completed, signed authorization to the address below.
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I hereby authorize Novixus Pharmacy Services and any of its parent companies, subsidiaries, or other affiliates and their respective employees to disclose Protected Health Information (PHI) of the member/insured listed below to those listed in section 2.

1. Member Information — Member # 1

Last Name	First Name	MI
Member Phone Number	DOB (MM/DD/YYYY)	
Street Address	City, State	ZIP

2. Authorized Representative

Last Name	First Name	MI
Member Phone Number	DOB (MM/DD/YYYY)	
Street Address	City, State	ZIP

3. Signature of Member

Signature of Member:	Print Name:	Date

1. Member Information — Member # 2

Last Name	First Name	MI
Member Phone Number	DOB (MM/DD/YYYY)	
Street Address	City, State	ZIP

2. Authorized Representative

Last Name	First Name	MI
Member Phone Number	DOB (MM/DD/YYYY)	
Street Address	City, State	ZIP

3. Signature of Member

Signature of Member:	Print Name:	Date

Mail form to: Novixus Pharmacy Services, P.O. Box 8004, Novi, MI 48376-8004