Evry Health
A Globe Life Company

Authorization to Disclose Protected Health Information

In order for Evry Healthcare to disclose to another person your Protected Health Information you must complete and signthis form and return it to us. You can send it back to us through secure message or by emailing it to support@evryhealth.com. Or mail the completed form to the below address. You have the right to receive a copy of this form.
Evry Healthcare Inc. PO Box 571208 Dallas, TX 75357

Full name: _____ Evry ID #: _____ Date of birth: _____

I authorize the following person(s) to access my health information:

Name:_____ Relationship:_____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

I'd like to keep specific conditions private (no selections required):

Please select which conditions should be kept private below:

- ☐ Mental health records
- ☐ Sexually transmitted infections (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Abortion/reproductive rights records

Otherwise, I authorize Evry to share all health information (including mental health, HIV and AIDS, alcohol/ drug abuse treatment, abortions records) with the parties and for the purposes described in this form.

How long should this authorization be in effect?

- ☐ Until the date my Evry coverage is terminated.
- ☐ This authorization should expire on : _____

If no expiration is specified, this authorization will expire 1 year from the date this form is signed.

Conditions of Authorization: I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the authorized people listed above and may no longer be protected by the rule.

Revocation/Cancellation: I have the right to revoke (cancel) this authorization at any time by sending a written notice to Evry at the address listed at the top of this form. Cancellation is effective upon receipt of this form by Evry. Revocation/cancellation will not affect any action taken by Evry in reliance on this authorization prior to receiving my written notice of cancellation. If I refuse to sign this form, mybenefits, coverage, and any payments will not be affected.

Signature required: I have read and understood the terms of this form.

Signature:_____ Date: _____

Note: This form must be signed by either the member or his/her personal representative. If you are not the member, please sign below and indicate your relationship by checking the appropriate box.

Representative signature:_____ Date: _____

Relationship: ☐ Parent ☐ Legal Guardian * ☐ Power of Attorney* ☐ Other*

*Documentation must be provided supporting your legal authority to act on the member's behalf