State of Washington

Navia Benefit Solutions Authorization for Release of Information

Important Information About Your Rights

- I may revoke this authorization at any time prior to its expiration date by notifying Navia Benefit Solutions in writing, but the revocation will not have any effect on any actions that Navia Benefit Solutions took before it received the revocation.
- I may see and copy the information described on this form if requested.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to seek assurances from the below named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.
- If the Covered Entity (employer) is requesting the authorization, then the participant must receive a copy of this authorization.

Information regarding this Authorization for Release of Information form:
I have read and understood the following statements about my rights. I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Participant Name: ____

SSN (or Employee ID if higher education):____

Please provide a description of the information to be used or disclosed (please specifically describe what you would like to have used or disclosed).

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Name the person or class of persons authorized to make the requested use or disclosure (for example, a specific customer service representative at Navia Benefit Solutions or name Navia Benefit Solutions as a class).

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Name the person or class of persons to whom Navia Benefit Solutions may make the disclosure (for example, a specific Human Resource (HR) person or HR as a class of persons at a specific agency).

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Describe the purpose for the requested disclosure (if you elect not to provide a statement of purpose you can provide a general statement such as “at the request of the individual”).

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Describe the expiration date or event of this Authorization for Release of Information (for example, a specific date, the end of the plan year, or once a specific claim is resolved, etc.)

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I understand that this authorization is voluntary. I may refuse to sign it and I may revoke it at any time in writing to Navia Benefit Solutions. For Participant's Representative please provide a description of authority to act on behalf of the participant.

Description of Authority (if applicable):____

Participant Signature: ______________________________Date: ___________________________