PATIENT ADVOCATES
THE WAY HEALTHCARE SHOULD BE

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I _____,
ID#_____
hereby authorize Patient Advocates, LLC to release to any representative of the following companies/organizations

_____
_____
_____
_____
_____
_____

information regarding claims payments and/or denials, health benefits, medical information, history and/or written records relating to my illness or injury, including any relevant, confidential information used in determining benefits.

*Information to be disclosed:
_____
_____

*Information NOT to be disclosed:
_____
_____

I understand that Patient Advocates, LLC, in compliance with state and federal law, will handle all information obtained in a confidential manner and will disclose this information only as is reasonably necessary.

I (___Do /___Do Not) want information released that relates to MENTAL HEALTH diagnosis or treatment.

I (___Do /___Do Not) want information released that relates to diagnosis or treatment in an ALCOHOL or DRUG ABUSE program.

I (___Do /___Do Not) want information released that consists of HIV TEST RESULTS, infection status, or treatment information.

This authorization is valid for as long as I am covered under this policy, unless it is revoked in writing. If this is signed after termination of coverage for the purpose of pursuing other party liability, this authorization is valid until it is revoked in writing or until the case has been closed by the contract administrator.

I understand that a photocopy of this authorization shall have the same validity as the original.

I understand that I am entitled to a copy of this form and that I have these rights: (Please Initial)

_____I may revoke my consent at any time and will notify Patient Advocates, LLC of this decision in writing. This will not effect my consent to release information which may have been given out before Patient Advocates, LLC received my notice.

_____I further understand that I may refuse to authorize disclosure of all or some of the health care information, but that refusal may directly affect the ability to determine benefits.

Patient Advocates, LLC
P.O. Box 1959
Gray, ME 04039
(207) 657-7733

PATIENT ADVOCATES
THE WAY HEALTHCARE SHOULD BE

_____	_____
Name of Patient/Employee (Please Print)	Date of Birth
_____	_____
Signature of Person/Patient/Employee	Date
_____	_____
Signature of Guardian/Responsible Party of Patient	Date
_____	_____
Signature of Witness	Date

Patient Advocates, LLC
P.O. Box 1959
Gray, ME 04039
(207) 657-7733