AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I __________________________ Date of Birth_________________ ID#__________________________________

Hereby authorize the following medical provider and/or institutions:

____ ____
____ ____
____ ____

to release to any representative of Patient Advocates, LLC medical information, history and/or written records relating to my illness or injury, including any relevant information for the specific purpose of implementing coordinated care management program on my behalf.

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 to review my medical records prior to release and understand reviews must be supervised.

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.

This authorization is valid until ____
(Specify date, not more than 1 year from date of signing)

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.

Patient Advocates, LLC
P.O. Box 1959
Gray, ME 04039
Phone (207) 657-7733 Fax (207) 657-7744

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

_____*(Initial)* 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.

____ _______________________
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
Phone (207) 657-7733 Fax (207) 657-7744