Medical Authorization Form

Client Information and Consent

MEDICAL AUTHORIZATION FORM

1. CLAIMANT'S INFORMATION

First Name | MI | Last Name

Claim Number | Social Security Number (Last 4 digits) | Employee Phone Number

Date of Birth (mm/yyyy) | Control Number

AUTHORIZATION FOR RELEASE OF INFORMATION

2. AUTHORIZATION FOR THE RELEASE OF INFORMATION TO HEALTH INFORMATICS SOLUTIONS *(This authorization is intended to comply with the HIPAA Privacy Rule.)*

I authorize and instruct any health plan, physician, health care professional, medical professional, hospital, clinic, laboratory, pharmacy, clearinghouse, data warehouse, or other organization that aggregates and maintains pharmacy data, MIB, Inc. (formerly known as the Medical Information Bureau), medical facility, or other health care provider or insurance company or producer that has provided treatment, payment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other information concerning me or my mental or physical health to Health Informatics Solutions and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize any insurance company, employer, the Social Security Administration, or other person or institutions to provide any information, data, or records relating to my Social Security, Workers' Compensation, credit, financial, earnings, activities, or employment history to Health Informatics Solutions.

For purposes of this Authorization, I acknowledge that any agreements I have made with My Providers that restricts the disclosure of my protected health information as described above do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction, including any restrictions on health care items or services for which a healthcare provider has been paid out of pocket in full.

Client Intake Form

Client Information and Consent

MEDICAL AUTHORIZATION FORM

1. CLAIMANT'S INFORMATION

First Name | MI | Last Name

Claim Number | Social Security Number (Last 4 digits) | Date of Birth (mm/yyyy)

AUTHORIZATION FOR RELEASE OF INFORMATION

4. AUTHORIZATION FOR THE RELEASE OF INFORMATION TO HEALTH INFORMATICS SOLUTIONS *(This authorization is intended to comply with the HIPAA Privacy Rule.)*

This information is to be disclosed under this Authorization so that Health Informatics Solutions may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage or benefits I have or have applied for with Health Informatics Solutions.

This Authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Health Informatics Solutions. I understand that a revocation is not effective to the extent that any of My Providers or Health Informatics Solutions has relied on this Authorization or to the extent that Health Informatics Solutions has a legal right to contest a claim under any insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and will no longer be protected by the HIPAA Privacy Rule governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release the entire medical record, Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to receive a copy of this Authorization.

Authorization for Release of Information to Health Informatics Solutions.

X _____ Date (mm/dd/yyyy)