

Authorization for the Release of Information

This document authorizes **Name of Company**, its care coordinator(s) and appointees to furnish information from its records regarding:

_____ (Print individual's name here)

The information this authorization releases shall be furnished by **Name of Company** on an appropriate "needs to know" basis only to my insurance companies, Medicare, my hospital or physicians, and/or to such employees or contractors or service providers as necessary in order to arrange services in my behalf and/or for my home.

I have released this information for the purpose of furthering my continuing medical care, or for resolving reimbursement claims, or enabling **Name of Company** to arrange and direct services for me within the understanding of my **Name of Company** membership.

Further, I authorize **Name of Company** to discuss my situation with the following member(s) of my family, or a neighbor or friend, when named below, if such discussion is deemed in my best interest and/or in the event of an emergency.

Persons approved: _____

This authorization may be revoked by me upon written notice sent to **Name of Company, Address**, and shall take effect immediately upon receipt. Such revocation shall have no effect upon information released before **Name of Company** received said notice.

Signature: _____

Address: _____

Date: _____

Witness: _____