Patient Consent & Release of Protected Health Information

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION
(Privacy Rule, 45 C.F.R. §164.508(c)(1)

SEND COMPLETED FORM TO:
Fax: **860-782-2091** or Email: **remede@priahealthcare.com**

I, _____(Patient Name & DOB)

Hereby Authorize_____(Practice Name)

to release my Protected Health Information (PHI) as described below to PRIA HEALTHCARE MANAGEMENT ("PRIA") and its employees/business associates as requested by them in connection with my Precertification, appeal, grievance and/or independent review request of a denial of insurance benefits and/or coverage, including but not limited to:

MEDICAL RECORDS: Hospital records, chart and notes; laboratory records and reports; physical therapy records; doctors and nurse's notes; all correspondence of any kind; psychiatric and psychological records, reports, tests and test results, x-ray films and reports; and, any and all other records which pertain to my medical care, treatment history and prognosis.

INSURANCE/BILLING RECORDS: Any and all communications, notes, billing statements, claim forms, Explanation of Benefits, or other documents to/from insurance companies, self-insured plans, TPA's, claims administrators, Plan Sponsors, Plan Administrators, utilization review companies or other third-party payers involved with evaluating, adjusting, processing or paying my claim(s) for insurance benefits, whether pre-service or post-service in nature.

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations. I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named above. I also understand that the covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form. Copies of this Release shall be treated in all respects as though an original, including facsimile transmissions, thereof. I have been advised of my rights to receive a copy.

This Authorization will expire one year from the date entered below OR upon conclusion of my appeal process.

I understand that I may revoke this Authorization at any time by notifying you in writing, but if I do, it will not have any effect on any actions you took before it received the revocation.

Patient Signature_____Date Signed_____

Member Designation of PRIA Healthcare Management As Authorized Representative

SEND COMPLETED FORM TO:
Fax: **860-782-2091** or Email: **remede@priahealthcare.com**

I, _____(Patient Name)

Hereby designate and appoint PRIA HEALTHCARE MANAGEMENT ("PRIA") and its employees/business associates to act as my authorized representative(s) with respect to my appeal of denied pre-service, concurrent or post-service claims by my insurance plan:

_____

(Insurance Plan/Claims Admin)

I authorize the above-named entity(s) to release to PRIA any and all Protected Health Information (PHI) as requested by them including any and all documents related to Member or Provider appeals/grievances, mental health and substance abuse information, claims and explanation of benefits (EOB) Information, enrollment and benefits information premium payment information. I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re -disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations. I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named above. I also understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party. This Authorization will expire one year from the date entered below OR upon conclusion of my appeal and/or IRO process.

I understand that I may revoke this Authorization at any time by notifying you in writing, but if I do, it will not have any effect on any actions you took before it received the revocation.

_____

(Patient Signature) (Date Signed)

_____

(Patient Date of Birth)

remedē Appeals Program Eligibility Agreement

SEND COMPLETED FORM TO:
Fax: **860-782-2091** or Email: **remede@priahealthcare.com**

(All paragraphs MUST be initialed, and the Agreement must be signed to be reviewed and processed)

_____(Patient Initials)

I understand I will be designating PRIA HEALTHCARE MANAGEMENT (including its employees and Business Associates) to act as my appointed Authorized Representative to assist me with appealing my **rem**edē® System insurance denial. I understand that if I am eligible and elect to participate I am not establishing an attorney-client relationship with PRIA HEALTHCARE MANAGEMENT or any affiliated or related entities/corporations. I also understand that I may withdraw from participation in the appeal process or rescind my appointment of PRIA HEALTHCARE MANAGEMENT at any time.

_____(Patient Initials)

I understand PRIA HEALTHCARE MANAGEMENT has not provided me with any guarantees or assurances that I am eligible for this program or, in the event I am eligible, I acknowledge that I have NOT been promised any specific outcome to my appeal and that this appeal may ultimately be denied or not processed by the payer.

_____(Patient Initials)

I understand that I may be asked to provide information, sign certain forms, obtain certain records or otherwise participate and assist PRIA HEALTHCARE MANAGEMENT during this appeal. I agree to respond to such requests in a timely fashion and understand that my failure to do so may negatively affect the outcome of my appeal. While I understand there are no costs for me to participate in this appeal program, some healthcare providers or other entities may require payment for copying medical records and if I want those records to be part of my appeal package, I will be directly responsible for paying those providers.

_____(Patient Initials)

I understand that the purpose of this appeal is to gain insurance approval for the **rem**edē System and this appeal will not address the amount of payment which the payer is required to render any health care provider or facility in the event I am approved. I understand that even if the **rem**edē System is approved, I will likely have personal financial responsibility to pay for services which are not covered by my insurance and I will have personal financial responsibility for any co-payments, co-insurance, deductibles, etc. as my insurance plan requires.

THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____
(Patient Signature)

_____
(Patient Name Printed)

_____
(Date Signed)