

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Patient Name: _____

Insured Name: _____

Insured I.D.: _____

Insured By: _____

Relationship to Patient: _____

I hereby authorize (**physician, hospital, or provider name**) _____ or their designee, to release and/or disclose verbally and/or in writing the above named individual's health information as requested regarding medical care and services provided

To: Fidelity Benefit Administrators, Inc.
201 International Circle
Hunt Valley, Maryland 21030

For the purpose of: Case Management
 Medical Necessity Review

Copies of Records Requested (**indicate only items which are minimally necessary to make a determination**):

- Complete Medical Record
- History & Physical
- Physician's Orders
- Discharge Summary
- Nursing Assessment
- Treatment Plan/Plan of Care
- Progress Notes/Updates

- Nutritional Assessment
- Lab/Radiology Reports
- Reports of Claims Payment
- Medication Profile
- Therapy Assessment(s) (PT/OT/ST)
- Activity Assessment
- Other _____

I understand that my records are protected under federal regulations governing Confidentiality of Personal Health Information (PHI) under HIPAA, and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization and must do so in writing and present the written revocation to the Privacy Officer of FBA. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this consent expires 12 months from this date. I understand that once information is disclosed per my authorization, the information may be redisclosed by the recipient in accordance with applicable laws and regulations and it may not be protected by federal or state privacy regulations. **I also understand that if I refuse to sign this form, the organization can refuse (select all that apply):**

Authorization for Treatment

Enrollment in health plan

Eligibility for benefits

If I have questions about disclosure of my health information, I can contact the Privacy Officer at FBA at (410) 329-0900. A duplicate photo static copy or facsimile reproduction of this authorization may be used in lieu of the original. I understand that I may keep a copy of this authorization form, after signing for my records.

Patient Signature

Date

Parent, Guardian, or Authorized Representative Signature

Date

Witness Signature

Date

