Community Health Partners[SM]

PHYSICIAN HOSPITAL ORGANIZATION

Case Management Authorization /Checklist

NAME (Print):______________________________ DATE:____________________

DATE OF BIRTH (MM/DD/YYYY):______________________

I have agreed to participate with Community Health Partners Case Management Program. I understand that under HIPAA regulations, my health information may be disclosed to any health care provider who is involved in my medical care, treatment or services, my health insurance plan and any medical billing clearinghouse who is involved with my insurance claims processing.

Under these regulations, individuals who are not involved in my care may not have access to my health information unless I authorize them to do so. For example, my spouse, other family members, friends, home nurses or aids, or other persons or organization who are not involved with my medical treatment, insurance plan or payment may not access my health information without my authorization. I hereby authorize the following designee to speak to with you about my condition(s). E.g. spouse, family members, life partner, etc.

Name (Print):______________________ Name (Print):____________________________

Name (Print):______________________ Name (Print):____________________________

I have completed and returned my medical release form ________

I have completed and returned my initial assessment questionnaire _______

I authorize the Case Manager to contact me in the following manner:

Work Phone Number__________________ Best time to Reach Me____________________

Home Phone Number__________________ Email Address______________________________

Cell Phone Number____________________ Primary Care Doctor Name____________________

This authorization will expire upon termination of enrollment in the health plan. I have read and understand the contents of this document.

Signature:_________________________________ Date:________________________________

Reviewed 08/13/18