



**AUTHORIZATION FOR RELEASE OF INFORMATION, INFORMED
CONSENT AND APPOINTMENT OF PATIENT REPRESENTATIVE**

Patient's Name

Date of Birth

Health Insurance Policy No.

Medical Record No.

I HEREBY AUTHORIZE THE RELEASE of information from my medical records for the purpose of financial reimbursement to **THE ABOVE AGENCY** for services rendered. I request that payment be made directory to **THE ABOVE AGENCY**. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct, and that this case is subject to Peer Review Organization quality review in the event of a written complaint.

I CONSENT TO RELEASE OF MY MEDICAL RECORDS to be reviewed by authorized representatives of Medicare, Medicaid, Blue Cross/Blue Shield of Michigan and/or my private insurance carrier(s). In addition, I authorize the records to be reviewed for audits within the agency.

I CONSENT TO THE RELEASE OF MEDICAL INFORMATION to physicians, hospitals, extended care facilities or community resources as needed.

I AUTHORIZE THE STAFF OF THE ABOVE AGENCY to carry out all procedures as ordered by my physician.

AUTHORIZATION OF PATIENT REPRESENTATIVE TO MEDICARE. In the event that my claim for benefit payment is denied, I appoint **THE ABOVE AGENCY** to act as my representative in connection with my claim under Title XVIII (Medicare coverage). I authorize this agency to make or give any request, to present evidence, obtain information and to receive notice in connection with my claim in asserted right wholly in my stead, with no fee incurred.

I understand that Medicare will pay 80% of these charges after the deductible and co-insurance (if applicable). I will pay 20% co-insurance and deductible.

A copy of this assignment has the same effect as the original.

I acknowledge that I have read the above information or it has been read to me.

Patient or representative: _____ **Date:** _____

Representative of THE ABOVE AGENCY: _____

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Are you currently enrolled in any **HMO**? Please circle **Yes** or **No**.

Are you covered under an employer group health plan based on your current employment or the current employment of your spouse? Please circle **Yes** or **No**.

*** If yes is noted on either of the above questions, please make sure that the information is correctly recorded on the admission sheet.
