AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION AND TO HANDLE CARECENTRIX ACCOUNTS

I authorize CareCentrix, Inc. (CareCentrix) and its affiliates to release my protected health information (PHI) contained in the records maintained by CareCentrix or a CareCentrix affiliate as specified below to the individual or entity identified below.

Name and address of individual whose PHI is being disclosed:

IMPORTANT All fields with an asterisk must be completed.

*Name: _____

*Address: _____

* City:_____ * State: _____ * Zip Code: _____

*Date of Birth:_____/_____/_____ *Phone Number: (_____)_____-_____

*Insurer:_____*Insurer ID Number: _____

CareCentrix Account Number (####-#####):_____

Name and address of individual/entity to whom the PHI is to be disclosed (Authorized Person):

*Name: _____

*Address: _____

* City:_____ * State: _____ * Zip Code: _____

*Date of Birth:_____/_____/_____ *Phone Number: (_____)_____-_____

*Relationship to Patient: _____

I agree that my PHI may be disclosed to the Authorized Person through various means of communication, including but not limited to, by phone, email, fax and US mail. The purpose for the disclosure of PHI is to discuss my health care services and treatment plan and/or handle my accounts with CareCentrix, including but not limited to, my patient billing account. I further agree that the Authorized Person has full authority to handle my patient billing and other accounts with CareCentrix, including but not limited to, receiving copies of invoices and billing ledgers, making payments, receiving refunds of any overpayments, and making changes to my account information.

I understand that the above information to be disclosed under this authorization may contain information about HIV, AIDS diagnosis/treatment, mental health diagnosis/treatment, alcohol/drug diagnosis/treatment, developmental disability, and/or abuse, and I expressly authorize the disclosure of such information unless otherwise specifically indicated below:

Do not disclose any information about:
◯ HIV/AIDS diagnosis/treatment ◯ Alcohol/drug diagnosis/treatment
◯ Mental health diagnosis/treatment ◯ Developmental disability ◯ Abuse

I understand that I have a right to revoke this authorization at any time by contacting CareCentrix in writing, except to the extent information has been released in reliance upon this authorization. I also understand that the information released in response to this authorization may be re-disclosed to other parties and no longer protected by the federal Privacy Rule. I understand that my treatment, payment for treatment, or enrollment or eligibility for benefits with my insurer cannot be conditioned on the signing of this authorization. I understand that the information requested is the property of CareCentrix and that a reasonable fee may be charged for the copying of any such records. Any facsimile or photocopy of this authorization shall authorize CareCentrix and its affiliates to disclose the information requested herein. This authorization shall be effective as of the date of execution set forth below and remain in effect for a period of five years at which time this authorization expires.

*Signature:_____ *Date: _____

*Printed Name:_____

If signed by anyone other than the patient, relationship of authorized representative to individual:

_____

If authorized representative of the individual please attach corresponding authorization documentation (power of attorney, etc.).

Please mail completed form to (both pages must be included)

CareCentrix, Inc.
Attention: Mail Room
9119 Corporate Lake Drive, Suite 200
Tampa, FL 33634

Or Fax to:
Fax Number: (866) 536-8046

Or Email to:
authorizationtodisclosephirequest@carecentrix.com