

APPENDIX 4

SAMPLE SUPPLEMENTAL AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

I authorize XYZ Hospital/EHO/Medical Practice to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers. I authorize XYZ Hospital/EHO/Medical Practice to release all medical information to my referring physician and my primary (family) physician. I also authorize them to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to XYZ Hospital/Medical Practice.

I agree that these provisions will remain in effect until I provide written revocation to XYZ Hospital/EHO/Medical Practice.

Signature of Patient/Legal Guardian: _____

Date: _____