AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Logo

Description automatically generated5800 Granite Parkway Suite 450

Plano, TX 75024

Return to Medical Management FAX:

866-308-9225 or EMAIL: [utilizationreview@payercompass.com](mailto:utilizationreview@payercompass.com)

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| **I. PATIENT INFORMATION** | |
| Patient Name: | Date of Birth: |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Home Telephone #: \_\_\_\_ |
|  | Cellular Telephone #: |
| Email Address: | Work Telephone #: |

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| **II. PROVIDER/FACILITY AUTHORIZED TO RELEASE PHI** | |
| Name: |  |
| Address: |  |
| Phone # | Fax #: |

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| **III. PERSON/FACILITY AUTHORIZED TO OBTAIN PHI** | |
| Name: | Relationship to Patient: |
| Address: | |
| Phone #: | Fax #: |
| Email Address: |  |

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| **IV. PHI REQUEST AND DELIVERY INFORMATION** |
| **Date(s) of Service or Date Range for Release:** |
| **Record Type(s): 🞏**Office Visits 🞏Immunizations 🞏Operative 🞏Radiology Report |
| 🞏Laboratory Test 🞏Other (specify): |
| **Purpose:** 🗹 Medical Benefit Plan Care Coordination including Utilization Review and/or Case Management |

I expressly consent to the release of information as designated above. **I understand that I have the right to revoke this authorization at any time and that if I revoke this authorization that I must do so in writing and present my written revocation to Payer Compass Medical Management Department. I understand that the revocation will not apply to PHI that has already been released as requested by this authorization. I understand that any disclosure of PHI carries with it the potential for redisclosure where confidentiality laws or regulations may not apply. It also prohibits Payer Compass Medical Management from making any further disclosure without the specific written authorization of the person to whom it pertains.**

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| **V. RELEASE OF PHI EXPIRATION DATE (MUST EITHER CIRCLE OR ENTER)** |
| 🞏Upon Death **OR** 🞏Expiration Date: / / **OR** 🞏One year from signature date. |

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| **Printed Name of Patient or Legal Representative/Authorized Health Surrogate\*** |  | **Date** |
| **Signature of Patient or Legal Representative/Authorized Health Surrogate\*** |  | **Date** |

\*Legal Representative/Authorized Health Care Surrogate is defined as a court appointed guardian or personal representative, a person with a Health Care Power of Attorney specific to medical records access, a person designated as a Health Care Surrogate, or next of kin. Supporting documentation required.

**Completed form can be returned by mail to the address at the top of this page, by fax to 866-308-9225** **or scanned and sent by email to** [utilizationreview@payercompass.com](mailto:utilizationreview@payercompass.com).