

MEDICAL RELEASE FORM

This form allows your health plan to access information regarding your medical history to effectively assist in coordination of your care. If you have any questions, please don't hesitate to contact us at 1-877-428-1286.

PATIENT INFORMATION

Patient Name:

Date of Birth: / /

Address:

City/State/ZIP:

Phone Number:

Email Address:

AUTHORIZED HEALTHCARE PROVIDER

I authorize the following healthcare provider to release my health information:

Provider Name:

Address:

Phone: Fax:

MEDICAL RELEASE

I hereby give my authorization for the release both verbally and in writing, of my medical records, to PERM FAIR, TPA and BillingNav LLC to include treatment diagnoses, diagnostic records, laboratory results, and other information in my health record to the health plan to utilize for care coordination and claims processes. This release is effective for one year following the date of my signature and applies to all current treating healthcare providers. I understand that I may revoke this authorization at any time by submitting a written request to the provider, except to the extent That action has already been taken. Make documents generic, not TPA specific (addressed in my request below)

Name of Patient/Guardian: Date:

Signature of Patient/Guardian: Date:

Please return completed Questionnaire along with this Medical Release form by:

 Email: help@permafair.com  Fax: 856-291-5300

With respect to the HIPAA Privacy Rule, a permissible use or disclosure of Protected Health Information is for Treatment, Payment, or Healthcare Operations per section 164.502(a)(1)(ii). This request is being made by the health plan and its Business Associate for determining eligibility and coverage under the plan, reviewing health care services for medical necessity, coverage, justification of charges, and the like; and utilization review activities which are defined as Payment per section 164.501 of the Privacy Rule.