COMPASSION*WORKS MEDICAL REIMBURSEMENT, LLC.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Notice: Coverage Specialists can help you better if they are able to work with other agencies. By signing this form you are giving permission to Compassion*Works Medical Reimbursement team to share/receive information about you.

Patient's Name:			**DOB:**	
Patient's Address:			**Social Security #:**	
City:	**State:**	**Zip:**	**Telephone #:**	**Email:**

Purpose: The information released will be used to evaluate my situation and to plan for and coordinate for me or for other purposes as specified.

I request and authorize the below individual to release healthcare information of the patient named above to:

I authorize:

Initial	**Name:** Raenette Franco at Compassion Works Medical **Phone:** 973-832-4736 **Fax: 973-387-1223**	**Purpose:**	All aspects of medical food and nutrition reimbursement coverage.

This request and authorization applies to (circle):

- ○ Healthcare information relating to the following treatment, condition, or dates
- ○ All healthcare information
- ◉ Other

Definition: I can cancel this at any time. I understand the cancellation will not affect any information that was released before the cancellation. I approve the release of this information. I understand that the information about my case is confidential and protected by the state and federal health information privacy laws. I have also read and agreed to Compassion Works Medical Reimbursement 's Notice of Privacy Practices. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

_____ _____

(Patient or Representative Signature) Date

_____ _____

(Name of Representative) (Relationship to patient)

EXPIRED AUTHORIZATION DATE (if any): _____/_____/_____