AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL RECORDS

Stay in Touch, LLC
Marta Martinez, Director
92 Main Street, Suite 202
Florence, MA 01062
tel 413.585.0606 fax 413 585.0603
www.stayintouchcenter.com

Patient's Name (print) ____________________ Date of Birth ____________________

Address ____________________ City __________ State __________ Zip __________

Telephone (H) ____________________ (W) ____________________

I hereby authorize Stay in Touch, LLC to obtain the release of any and all medical records concerning my care from any physician, hospital, or other provider of medical care to me at any time.

I also authorize Stay in Touch, LLC to release any and all records concerning my care to Medicare, any insurance company, third-party administrator, or managed-care entity.

Such medical records may contain information pertaining to drug or alcohol abuse, HIV testing, AIDS diagnosis or treatment, or mental health treatment.

I understand that I may, in writing, revoke this consent at any time unless information has already been released.

Patient's Signature ____________________ Date ____________________

Witness's Signature ____________________ Date ____________________

REVOCATION OF CONSENT

I hereby revoke all authorizations given above. (Front of document to be crossed out.)

Patient's Signature ____________________ Date ____________________

Witness's Signature ____________________ Date ____________________

CLAIM INFORMATION

Name ____________________ DOB __________ SS# ____________________

Claim# ____________________ Insured Name ____________________ DOA __________ DOB __________

Insurance Carrier Name ____________________ Carrier Address ____________________

Adjuster ____________________ Carrier Phone ____________________

Attorney Name ____________________

Address ____________________ Phone ____________________

Primary Health Care Provider ____________________

Address ____________________ Phone ____________________

ID# ____________________ Policy# ____________________