HIPAA Compliant
(Health Insurance Portability and Accountability Act of 1996)

COMPASSION*WORKS MEDICAL REIMBURSEMENT, LLC.

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HIPAA

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

Purpose: The information released will be used to evaluate my coverage and affordability with my health insurance including any other situations to help plan for and coordinate for me or for other purposes as specified below.

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 the following:

- Medical foods designed for the treatment of inborn error of metabolism, rare diseases and any other special medical conditions. Also known as formula or low protein foods.
- Enteral formula for the consumption of oral or tube feedings.
- Nutritional supplements such as vitamins and add-ons for the dietary need of a specific medical condition.

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): _____/_____/_____

Updated 01/28/2020