HP Enterprise Services
950 North Meridian Street
Suite 1150
Indianapolis, IN 46204
www.hp.com

TO: **IFSSA/OMPP/IHCP/Indiana Medicaid/**

HP Enterprise Services

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Person whose records are to be released:

Patient Name d.o.b. SSN

Address

City State Zip Code

I HEREBY AUTHORIZE AND CONSENT TO A DISCLOSURE OF THE FOLLOWING INFORMATION FROM THE ABOVE PATIENT'S HEALTH RECORD:

__**XX**__ **All records (See description below)**

Date(s) of Treatment requested: (can specify "All dates"): _____

Purpose for Release of Health Information: **lien resolution/litigation**

Records are to be released to: Lien Resolution Group

55 Old Nyack Turnpike Rd. Ste. 311

Nanuet, NY 10954

I understand that this Authorization may be revoked by me in writing at any time, except to the extent that the covered entity has taken action in reliance thereon.

I understand that this Authorization for release of protected health information includes release of records relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), records of treatment for physical and/or emotional illnesses, records of treatment for alcohol or drug abuse, and records pertaining to communicable diseases and genetic testing. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. By signing this Authorization, I acknowledge that I have read and understand this Authorization and further, I authorize the use or disclosure of my protected health information in accordance with the terms of this Authorization.

This Authorization expires: **Upon termination of litigation and lien resolution.**

Date: _____ _____

Authorized Signature of patient, guardian, parent, emancipated minor, or personal representative

Relationship to patient or title: _____

Section C: Personal Representative Agreement and Signature

As the authorized personal representative of _____, I understand that I am representing the above named IHCP member and certify that the information contained herein is true to the best of my knowledge. I also certify that I will only use the above named member's health information for assisting the member with his or her health care.

Personal Representative Signature: _____ Date: _____

Personal Representative Name: _____ Date: _____

If this request is from a personal representative on behalf of the IHCP member who has power of attorney or guardianship rights, please provide a copy of the documentation to support the representation.

This form must be notarized if submitted only with the member's personal representative signature.

Subscribed and sworn (affirmed) before me this _____ day of _____, _____

Signature: _____

Notary Public in and for the state of _____

In the county of _____

(Affix seal)

My commission expires: _____

Please mail this completed form and supporting documentation, if required, to the following address:
IHCP Privacy Office
P.O. Box 7260
Indianapolis, IN 46207-7260