DATE: _____/_____/_____

MEDICAL RELEASE FORM

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Please complete this form to authorize the healthcare provider(s) and its physicians, employees and agents listed below to release or disclose to the Some Other Company Inc. Dba Pretty in Pink Boutique and its representatives all medical records, including records pertaining to treatment, prognosis, and diagnosis.

Patient Name: _____ Date of Birth (MM/DD/YYYY): _____

Address: _____ Social Security (last four): _____

Permission to Share: I give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal to Some Other Company Inc. Dba Pretty In Pink Boutique.

PHYSICIAN INFORMATION

Treating Physician Name: _____

Hospital/Facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

MEDICAL RECORDS TO BE RELEASED

- ☐ Medical Records Abstract:
  - History & Physical
  - Operative / Procedure Reports
  - Clinical / Office Notes
- ☐ Operative Notes
- ☐ Supporting physician notes for services requested
- ☐ Physician order/Certificate of Medical Necessity (CMN) for original date of service and renewal orders /CMN covering through date of service requested

REASON FOR RELEASE

In according to CMS Standard Documentation Requirements for All Claims Submitted to DME MACs Article A55426:

- A prescription is not considered to be part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record.
- The beneficiary's medical record must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the beneficiary's diagnosis and other pertinent information including, but not limited to, duration of the beneficiary's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.

AGREEMENT

I hereby authorize the healthcare provider(s) and its physicians, employees and agents listed within this form to release or disclose to the Some Other Company Inc Dba Pretty In Pink Boutique and its representatives all of my medical records, including records pertaining to treatment, prognosis and diagnosis. I further authorize the healthcare provider(s) and its physicians, employees and agents listed within this form to provide to and discuss with Some Other Company Inc Dba Pretty In Pink Boutique and its representatives any confidential information with respect to my medical condition or treatment, either formally or informally.

I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by the above-named healthcare provider(s) or its physicians, employees or agents before the healthcare provider(s) received my revocation. Should I desire to revoke this Authorization, I must send written notice to the healthcare provider(s). I understand that I am not required to sign this Authorization. The above-named healthcare provider(s) will not condition treatment, payment, enrollment, or eligibility for benefits on whether I provide this Authorization. However, I further understand that if I do not sign this Authorization, I may not be eligible to obtain benefits from my insurance or Some Other Company Inc dba Pretty In Pink Boutique since most insurance must have competent medical records to document and verify that the required services and DME supplies are used to prevent, diagnose or treat a sickness, injury, disease or symptoms.

I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the above-named healthcare provider(s) or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment or healthcare operations, or as otherwise permitted by law.

This authorization expires 12 months from the date it was signed OR as specified: _____/_____/_____If not specified, this authorization will expire 12 months from the date it was received.

_____ _____ _____

PATIENT OR AUTHORIZED REPRESENTATIVE'S SIGNATURE | PRINT NAME | RELATIONSHIP TO PATIENT