Healthcare Navigation, LLC

CLIENT AUTHORIZATION FORM

I, _____, have retained Healthcare Navigation, LLC (HN), to represent me with respect to medical/health insurance coverage issues and/or to evaluate my healthcare coverage or coverage options. As appropriate, I authorize HN to complete/submit health insurance claim forms and/or to review and to investigate medical/hospital bills and insurance statements, to assist in obtaining authorization for services, to appeal any denial of medical services, to represent me in any proceeding regarding such appeal, and to assist in other related matters at my request as indicated in the HN Professional Services Agreement.

I authorize the release of all benefit, billing, medical, utilization, claim, discharge planning, coordination of benefits, treatment planning or other information related to my care to the authorized individuals from HN identified below. I further authorize these individuals to obtain information from staff in organizations involved in billing and processing claims on my behalf and from staff working for doctors, hospitals, or any other provider of care. I request that those organizations and individuals cooperate with and release relevant information to authorized individuals from HN.

HN is committed to protecting the privacy and confidentiality of protected health information. Staff will only release information necessary to accomplish the tasks or resolve the issues for which we have been retained and will only release information to individuals or organizations involved in the activities identified above and to other authorized individuals at the client's request like family members, accountants, bookkeepers or attorneys. Protected information may be shared among HN staff but will not be released except in the circumstances described above. Any other release of information or breach of client confidentiality is a violation of policy.

This authorization shall remain in effect for at least three months after the conclusion of a client project or relationship or until revoked in writing by the client.

_____

Signature

_____

Street Address

_____

City, State, Zip Code

_____

Healthcare Navigation, LLC

_____

Date