



8310 Clinton Park Drive, Fort Wayne, IN 46825
(260) 482-7400 OR 1-800-837-7400
Fax (260) 482-8991

Authorization for Release of Information

I. Information About the Use or Disclosure

I hereby authorize the use or disclosure of health and personal information about me, including HIV, AIDS ARC or mental health as described below. I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Patient Name: _____ ID Number _____

Persons/Organizations authorized to release information to Benicomp, Inc: _____

Specific description and dates of the information that may be disclosed: _____

All chart notes, transporting notes including history, medication and diagnosis

Specific purpose of the disclosure: _____ Medical Review _____

This Authorization will expire on 1 year from signature date

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before receiving the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

III. Signature of Patient or Patient's Representative

Signature of Patient or Patient's Representative
(Form must be completed before signing)

Date

Printed Name

Relationship to Patient