HIPAA AUTHORIZATION FOR CCM TO RECEIVE & DISCLOSE PROTECTED HEALTH INFORMATION

Please read this authorization carefully and confirm your agreement to this authorization by signing where indicated on the back of this form.

PURPOSE: This form is used to authorize Corporate Care Management, (CCM) 1 Kattelville Road, Suite 5, Binghamton, NY 13901 to receive protected health information while working in the capacity of the Utilization Review and/or Case Management agent for your Group Health Plan, Workers' Compensation Plan, Disability Plan or other Benefit Plan offered by my employer. This form also authorizes Corporate Care Management to further disclose the protected health information it may receive to either your Plan's Claims Administrator, your Plan's designated Plan Administrator and to any carrier(s) (including workers compensation, auto, and health) which may have provided benefits related to your injury or illness. This authorization is voluntary.

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1. **Individual/Patient (include Name, Address, and Date of Birth):**

2. **Person(s) or Organization(s) Authorized to Disclose:** You authorize the following person(s) and/or organization(s) to disclose the protected health information to Corporate Care Management, Inc., (CCM) as described below.

[ ] Any health care providers CCM deems necessary to perform its duties.

[ ] Only those specified here:_____

3. **Purpose of this Authorization:** Please note, that by signing this form, you will authorize Corporate Care Management, Inc. to receive and disclose your protected health information for the purpose of reviewing claims, benefit requests or providing case management services offered through your Employer's benefit plan.

[ ] To review a claim or a request for:

[ ] Other:

4. **Protected Health Information to be Received and Disclosed**: Please note, that by signing this form you authorize Corporate Care Management, Inc., to both receive and disclose the specific protected health information indicated below for the purpose(s) stated above.

This does NOT include Psychotherapy, Alcohol/Substance Abuse, and/or HIV (AIDS) notes unless the box is marked with an X. You may also use the NYS Department of Health Authorization Form for this purpose.

[ ] Please Include Psychotherapy/Alcohol/Substance Abuse notes
[ ] Please Include HIV (AIDS)

[ ] History & Physical	[ ] Consultation Reports	[ ] Therapy Notes	[ ] Pathology Report
[ ] Nurses Notes	[ ] Discharge Summary	[ ] Operative Report	[ ] Discharge Summary
[ ] Physician Orders	[ ] Physician Notes	[ ] Other:	

5. Please list any items you wish to be excluded from this authorization:
_____

6. **Expiration**: This authorization will expire upon the completion of purpose described in item 3 above.

7. **Signature**: You may refuse to sign this authorization. However, without a signature, the authorization is not valid.

   I, (please print) _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that Corporate Care Management Inc., (CCM) may receive protected health information from the persons and/or organizations named in this form and may also disclose protected health information described in this form for the purposes stated on this form. I understand that this authorization is only valid while enrolled in my current benefit plan or I have claims being processed for a benefit plan with which I was once enrolled.

   I understand that I may revoke this authorization at any time by giving written notice of revocation to the office listed below. Revocation of the authorization will not affect any action taken in reliance on this authorization before written notice of revocation is received.

   Signature: _____Date: _____

   If a personal representative on behalf of the individual signs this authorization, please complete the following:

   Personal Representative's Name: (please print) _____

   Description of Authority: _____

   Personal Representative Signature: _____

   Date: _____

A personal representative must provide legal proof of representation, e.g. Attach copy-Power of Attorney (POA).

Please complete and return this form to:

Corporate Care Management, Inc.
1 Kattelville Road, Suite 5
Binghamton, NY 13901-1294

FAX: 1-607-648-3444

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS