



Case Management Authorization/Checklist

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

I have agreed to participate with Community Health Partners Case Management Program. I understand that under HIPPA regulations, my health information may be disclosed to any health care provider who is involved with my medical care, treatment or services, my health insurance plan and any medical billing clearinghouse who is involved with my insurance claims processing.

Under these regulations, individuals who are not involved in my care may not have access to my health information unless I authorize them to do so. For example, my spouse, other family members, friends, home nurses or aids, or other persons or organization who are not involved with my medical treatment, insurance plan or payment may not access my health information without my authorization. I hereby authorize the following designee to speak with you about my condition (s). E.g. spouse, family member, life partner, etc.

Name (Print): _____ Name (Print): _____
Name (Print): _____

I have completed and returned my medical release form []
I have completed and returned my initial assessment questionnaire []

I authorize the Case Manager to contact me in the following manner:

Work Phone Number: _____ Best Time to Reach Me: _____
Home Phone Number: _____ Email Address: _____
Cell Phone Number: _____ Primary Care Doctor: _____

This authorization will expire upon termination of enrollment in the health plan. I have read and understand the contents of this document.

Signature: _____ Date: _____