Authorization to Release Information

09/08/2004

Patient Name _____

Social Security # _____

Birthdate _____

Street Address _____

City _____ State _____ Zip _____

Telephone # _____

I hereby request and authorize EIP, Inc. to disclose the indicated information to:

Facility/Doctor/Group Name _____

Telephone Number _____ Fax Number _____

Street Address _____

City _____ State _____ Zip _____

Appointment date, if known _____

- ❑ Radiology report
- ❑ MRI images/films, if applicable
- ❑ Other (please specify) _____

The purpose or need to disclose this information is:

- ❑ Continuing Care
- ❑ At the request of the patient
- ❑ Insurance Issue
- ❑ Other

I understand that EIP, Inc. may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that once the indicated information is released by EIP, Inc., they are unable to take back any information they have already shared with my permission.

I HAVE READ AND UNDERSTAND THE NATURE OF THIS RELEASE OF INFORMATION AS INDICATED ABOVE. THIS AUTHORIZATION SHALL BE VALID UNTIL THE DISCLOSURE IS COMPLETE OR UP TO 90 DAYS AFTER THE DATE BELOW, AFTER WHICH TIME IT SHALL EXPIRE. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY CONTACTING EIP, INC.

Patient *or* Authorized Representative Signature _____ Date _____

Patient Name _____
Applicable only if authorized representative signs for patient

_____
Relationship to patient *or* Description of representative's authority to act for patient

EIP Representative _____

EIP, Inc.
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Wexford, PA 15090
1-866-398-7364 (phone)
1-866-267-0144 (fax)