Patient Advocate Foundation Authorization

_____ (print name) authorizes Patient Advocate Foundation (otherwise known as PAF), to intervene on their behalf in an effort to resolve matters relative to pursuing insurance authorization and payment.

The undersigned authorizes PAF to give and receive information to and from representatives, identified as pertinent to the matters described by the patient or their representative in conversations with PAF representatives, or with parties identified in documents forwarded to PAF as part of the patient's case records. If needed, names, addresses and phone numbers for parties pertinent to resolution of the matters will be requested of the patient or their representative and may likewise be communicated to the representatives. Copies of any of the materials provided to PAF may be forwarded to parties involved as necessary.

Representatives of PAF may utilize and release information provided by the Patient and/or a third party on Patient's behalf. Representatives of PAF include attorneys who are in the National Legal Resource Network and/or case managers and its' staff members who are seeking resolutions to the matters described during the Patient Intake.

The Patient further authorizes PAF and/or its' representatives to release patient information, without reference to patient's name, address, or any identifiable part, for use by legislative bodies and policy makers seeking health care reform. This authorization to release information is confirmed by the signature below. I reserve the right to withdraw this authorization at any time by written notification to PAF.

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature. This authorization may be revoked in writing by the undersigned at any time. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke this authorization.

Date: _____

Patient Signature: _____

If Patient is unable to sign please state reason:

_____

Patient Contact Information

Address_____

City _____ State _____ Zip Code _____