MAGNACARE™

care right here

Customer Service Department
825 East Gate Blvd.
Garden City, NY 11530

Re: Confidential Health Information Consent Form

Dear

Pursuant to a recent request, enclosed is a Confidential Health Information Consent Form for you to complete. By signing this form you are giving your consent to allow MagnaCare to speak to the person you have designated to be a personal representative to act on your behalf. This form will be kept on file in our office and will remain in effect until you notify us in writing otherwise.

Instructions for completing this form:

- Please check off who this disclosure applies to (yourself or your minor dependent(s))
- Print the name of the person whom you have designated as your personal representative and have authorized to receive protected health information in the space provided

Fill in the patient and member information requested in the spaces provided. Sign and return the completed form to the address listed above.

Please feel free to contact Customer Service with any questions at: 1-800-352-6465 (ASC)

Sincerely,

ASC Customer Service

MAGNACARE
CONSENT TO USE, DISCLOSE OR ACQUIRE
CONFIDENTIAL HEALTH INFORMATION

By signing this form, I agree on behalf of (check one) __ myself __my minor children/dependents, that MagnaCare and its affiliates and its employees and agents may use or disclose to _____(check one) __my/__my minor children(s)/dependent(s)

Enter name of the person who you designate as your personal representative

confidential health and other individually identifiable information for the purposes of treatment, payment or health care operations, as those terms are explained in MagnaCare's Notice of Information Privacy Practices. My consent includes my agreement for the use or disclosure of confidential health information that may include diagnosis, prognosis, treatment and payment information related to physical and/or mental illness, including, but not limited to: substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC), human immunodeficiency virus (HIV), communicable diseases or genetic conditions.

Patient Name: _____

Primary Member Name: _____

Patient Signature: _____

Primary Member ID No: _____

Home address: _____

_____

Home Telephone: _____ Date: _____

Employer/Fund: _____

Minor Child(ren)/Dependent(s)' name(s), when applicable:

_____

_____

_____

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