

## The Marden Companies

### **AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION**

The purpose of this form is to help you in submitting an authorization for the release of your health care information to other individuals or entities. An authorization permits us to disclose your health care information for purposes other than those permitted for treatment, payment and our health care operations and as set forth in our Notice of Privacy Practices.

You are not required to use this form, but in accordance with federal standards, all of the information presented on this form IS required before we can process your request. Therefore, it may be easier for you to use this form. Please type or print this form. You should send this form or your written authorization to: **Privacy Coordinator, The Marden Companies, P.O. Box 941, 200 Putnam Street, Suite 800, Marietta, OH 45750** or you may fax this request to 1-800-937-2648. Additional copies of this form are available at our website at [www.mardencompanies.com](http://www.mardencompanies.com) or from our Privacy Coordinator. We may charge a fee for the costs of copying, mailing, or other supplies associated with this request. For information on fees and charges, please contact our Privacy Coordinator.

**By signing this form, you are acknowledging that you understand that this authorization is voluntary and that you are asking us to disclose health care information as described below. We will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization. However, we may condition performance of your pre-employment evaluation on whether you provide this authorization to The Marden Companies because the information is being created solely for the purpose of disclosure to your prospective employer.**

You have the right to revoke this authorization in writing at any time, with limited exceptions as set forth in item number 9 below. We will maintain a copy of this authorization as part of your record of service with us. Please remember that once we release this information, some potential may exist for the information to be disclosed by the recipient, as we have no control of the information or its use once it leaves our possession. Health care information re-disclosed by the recipient may no longer be protected by law.

We cannot process your request unless this authorization is fully completed, signed and dated. You understand that signing this document is voluntary, but failure to sign it or revoking an authorization for disclosure of information related to a pre-employment evaluation could result in a negative decision by your prospective employer.

#### TO BE COMPLETED BY THE INDIVIDUAL REQUESTING THE DISCLOSURE

(1)

<b>Patient Name:</b>			
<b>Home Phone:</b>		<b>Work Phone:</b>	
<b>Street Address:</b>		<b>City:</b>	
<b>State/Zip:</b>		<b>Date of Birth:</b>	
<b>E-Mail (Optional):</b>		<b>Today's Date:</b>	

**(2) This is a request regarding services received from and the information may be disclosed by** (check as applicable):

- Marden Rehabilitation Associates of Ohio, Inc. (outpatient therapy)
- Marden Rehabilitation Associates of West Virginia (outpatient therapy)
- Health Care Plus (home health services)
- Preferred Care Plus (private duty)
- Marden Physician Services, Inc. (medical practice)

**(3) Service was received at** (please state street and city of the location at which services were received) \_\_\_\_\_ **in the state of** (check one):  Ohio  Pennsylvania  West Virginia.

**(4) Please provide a description of the information to be disclosed.** Please be as specific as possible so that we can understand your request. For example, you may say "all therapy services performed at the Woodsfield, OH clinic in July and August 2003" or "all my home care services from Health Care Plus in 2003." We will only disclose the information described, even if we have other information about you. We can also disclose *all* of the information we have about you, if you check "Entire Record." (Check one):

- Entire record (including services provided after the date this authorization was signed but before the expiration date).
- Information for the time period from \_\_\_\_\_ to \_\_\_\_\_
- Information related to (please specify): \_\_\_\_\_

**(5) Please identify to whom the information should be disclosed:**

<b>Name of Entity:</b>	<b>Department (if known):</b>
<b>Name of Person (if known):</b>	<b>Street Address:</b>
<b>City:</b>	<b>State/Zip:</b>
<b>Telephone No:</b>	<b>Facsimile No:</b>

**(6) All disclosures are made via regular U.S. mail, unless you provide other specific transmittal instructions.** (If applicable check and complete one):

- I will pick up the information on \_\_\_/\_\_\_/\_\_\_
- Fax to: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

**(7) The purpose for this disclosure is** (check one):

- At my personal request
- Insurance application/claim
- Disclosure of pre-employment testing results to my prospective employer
- Other \_\_\_\_\_

**(8) This authorization expires on** (check one and indicate the expiration date or event):

- Expiration date: \_\_\_\_\_
- Expiration event: \_\_\_\_\_

If no expiration date is indicated, this authorization will expire one year from the date on which it was signed.

**(9) You have the right to revoke this authorization** in writing at any time, except to the extent that action has been taken in reliance upon this authorization. To revoke this authorization, please send a letter to the Privacy Coordinator at the address above or submit your notice of revocation electronically to [privacy@mardencompanies.com](mailto:privacy@mardencompanies.com). Please refer specifically to this authorization when making your revocation. Please keep a copy of this authorization.

\_\_\_\_\_  
Signature (Patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Authorized Representative)

\_\_\_\_\_  
Date

**AUTHORITY TO ACT:** If you are making this request on behalf of someone else, please describe your relationship with or source of authority to act on behalf of the patient: \_\_\_\_\_

\_\_\_\_\_