## The Marden Companies

# AUTHORIZATION TO REQUEST RELEASE OF HEALTH CARE INFORMATION FROM OTHER HEALTH CARE PROVIDERS TO THE MARDEN COMPANIES

The purpose of this form is to help you in submitting an authorization for the release of your health care information from other individuals or entities to The Marden Companies. Although not legally required, some health care providers require an authorization prior to disclosing information to other health care providers even for treatment purposes. The purpose of this authorization is to facilitate our ability to obtain your health care records from other health care providers to help us coordinate your care.

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 or from our Privacy Coordinator.

**By signing this form, you are acknowledging that you understand that this authorization is voluntary and that you authorize your health care information to be disclosed to The Marden Companies as described below. You have the right to revoke this authorization in writing at any time, with limited exceptions as set forth in item number 7 below. We will maintain a copy of this authorization as part of your record of service with us. We will not condition treatment, payment, enrollment or eligibility for benefits on whether you provide this authorization to The Marden Companies. Please note that, we may further disclose the information we receive pursuant to this authorization at your request. Once such re-disclosure is made, there is a chance that the information will be further disclosed by the recipient, as we have no control over 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.**

**This authorization must be fully completed, signed and dated for your request to be processed.**

**(1) Please provide the following information:**

| | |
|---|---|
| **Patient Name:** | **Work Phone:** |
| **Street Address:** | **Home Phone:** |
| **City:** | **Date of Birth:** |
| **State/Zip:** | **Today's Date** |
| **Email (optional):** | |

**(2) I am requesting that the following individual/entity disclose information to The Marden Companies:**

| | |
|---|---|
| **Name of Entity:** | **Department (if known):** |
| **Name of Person (if known):** | **Street Address:** |
| **City:** | **State/Zip:** |
| **Telephone No:** | **Facsimile No:** |



 

**(3) Please provide a description of the information to be disclosed.** (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):_____
_____

**(4) Please identify to whom the information should be disclosed at The Marden Companies:**

| | |
|---|---|
| **Name of Entity:** | **Department (if known):** |
| **Name of Person (if known):** | **Street Address:** |
| **City:** | **State/Zip:** |
| **Telephone No:** | **Facsimile No:** |

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

□ At my request
□ Other_____

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

□ Expiration date:_____
□ Expiration event: _____

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

**(7) 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, write a letter to the entity referenced in number 2 above telling them that you want to revoke the authorization. Please send a copy of the revocation letter to The Marden Companies' Privacy Coordinator at the above address or submit a copy of your revocation notice electronically to privacy@mardencompanies.com. Please refer specifically to this authorization when making your revocation. Please keep a copy of the revocation.

**(8) A copy of this authorization will be provided to you. Please retain your 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: _____
_____



 