PerformCARE

Authorization for Use or Disclosure of Health Information

1. **Member:** I hereby authorize PerformCare to use/disclose the following Protected Health Information from the records of:
   Name:_____ Date of Birth:_____
   Address:_____
   Telephone: _____ MA Recipient #: _____

2. **Description Of Information To Be Used And/Or Disclosed:**:

   All information received, in written form and verbally, by PerformCare for support of the request the approval of services including any historical data which is considered relevant to the discussion of the authorization/denial of services for the Member. All information is relevant to a discussion/review of the delivery of services by a PerformCare network provider or by PerformCare.

3. **Who Is Authorized To Use And/Or Disclose The Information?**
   Specify what organization or entity is authorized to use and/or disclose your health information, e.g., "PerformCare or Dr. Jones"
   This information is to be disclosed by PerformCare for the purpose of processing _____ only. The _____ was opened to dispute the denial of services dated _____. This request is being made by the Member/Authorized representative.

4. **Who Is Authorized to Receive The Information?**
   - Name the individual(s) and/or entities that are authorized to receive the above information, e.g., for a grievance list all the individuals you are inviting to the meeting/for a complaint list the provider the complaint is filed against.

   _____

   _____

5. **Reason the Information Will Be Used And/Or Disclosed:**
   For the purpose of processing this specific complaint or grievance filed by the Member or their representative.

6. **Expiration Date or Event, if any (if none mark as N/A): _____**

_____

Signature of Member or Personal Representative Date