Medical Records Release

I hereby authorize Keystone Peer Review Organization, LLC d/b/a Acentra Health ("Acentra Health"), the Independent Assessment Entity, which has contracted with the NC Division of Health Benefits, to release and disclose the pertinent medical information and records in its possession to my PCS Provider, Case Manager, Caregiver, etc. (listed below) for the specific purpose of facilitating my assessment and related care coordination, including communications about my health status, care needs, and related services, except for appeals.

_____

Provider Name: _____ Phone Number: _____

Beneficiary Name: _____ Date of Birth: _____

Covered medical information and records are limited to a copy of the referral, assessment, and any notifications as they pertain to assessment determinations. I have full knowledge of and understanding of this request and the personal information authorized to be disclosed.

I understand that this authorization will expire on the following date, event, or condition: _____. I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time by providing written notice. Verbal revocations will not be honored to ensure proper documentation of my intent to revoke. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.
I understand that my information may not be protected from re-disclosure by the recipient. However, if this information is protected under Federal Substance Abuse Confidentiality Regulations (42 CFR Part 2), or any other applicable federal or state privacy laws, the recipient is prohibited from re-disclosing such information without my further written consent unless permitted by law. I acknowledge that re-disclosure of sensitive information, such as HIV status, psychiatric care, or substance abuse records, may carry legal consequences.

If my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, I specifically consent to the release of such sensitive information.

I acknowledge that the records being disclosed may include sensitive information, such as HIV status, substance abuse records, or psychiatric information. Initial: _____

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to be assessed, approved, or provided with any authorized services. I further understand that I may request a copy of this signed authorization.

_____ _____

Beneficiary/Legally Responsible Person's Printed Name **Date**

_____ _____

Beneficiary/Legally Responsible Person's Signature **Date**