CATCH

"A local solution to a national problem"

PERMISSION TO RELEASE AND RECEIVE INFORMATION
Compliant with HIPAA

The purpose of this disclosure is to determine my eligibility to participate in the Coordinated Access to Community Health, arrangement of medical services through CATCH, and facilitation of my participation in pharmaceutical programs by CATCH. I hereby authorize you to release any medical and non-medical information in your possession, custody or control regarding me pursuant to this Authorization.

I, the undersigned, hereby authorize any and all physicians, hospitals, clinics, other medical-related facilities, insurance companies, employers, Federal, State, and County agencies to release any records and information requested for CATCH applicant/ member(s) listed below.

Please release this information to **CATCH, 2040 Timberbrook Lane, Springfield, IL 62702** its employees, associated physicians, hospitals, pharmaceutical company representatives, and representatives of other agencies providing medical benefits as requested. I consent to disclosure of my personal health information to these parties, but only as needed to perform regular operations.

I understand that I may revoke this Authorization at any time by requesting such to CATCH in writing at the above address. This authorization shall remain valid for one year from the date signed below and I know I may request a copy of it. A copy of this shall be considered as valid as the original.

Enrolling Adult who is the Household: _____ Birth date: _____

Enrolling Spouse: _____Birth date: _____

_____ _____
Signature of Head of Household Date

_____ _____
Witness Date