

Authorization to Share Health Information

I, _____, allow my doctor(s), my health plan or insurers, and any other healthcare providers to give medical information relating to my use or need for weight loss surgery to P-Verify, Inc.

P-Verify, Inc. runs the Bariatric & Metabolic Intelligence (BMI) Reimbursement Support Program. This information can include spoken or written facts about my health or payment benefits I may have. It can include copies of records from my healthcare providers or health plans about my health or care.

P-Verify, inc. will use and give out this information to check to see if I have coverage for weight loss surgery. I know that people who work for and with P-Verify, Inc. may use and see my information, but they may use it only as allowed in this form.

This Authorization will last for 3 years after the date I sign this form. If I change my mind before that time, I can tell my doctor, healthcare provider, and/or my insurer in writing that I do not want them to share any more information with P-Verify, Inc. but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my healthcare providers or insurers have given to P-Verify, Inc.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my healthcare providers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the BMI Reimbursement Support Program.

I understand that P-Verify, Inc. does not promise to find ways to pay for my weight loss surgery, and I know that I may have to pay the costs of my care.

Patient Signature: _____ Date _____
(If the patient is unable to sign, patient's representative must sign below)

Patient's Name: _____

By: _____
(Signature of person signing for patient)

Describe relationship to patient and right to act for patient:
