Achieve Healthcare, LLC
7850 Riverdale Drive; Suite D
Ramsey, MN 55303
Phones: 218-829-9497 or 763-913-1325
Fax: 763-712-3916

Authorization for Use and Disclosure of Information

Consumer Name: _____

Medical Assistance #: _____

Start Date: _____

Treatment of Confidential Information. Achieve Healthcare LLC, acts as your PCA Choice Provider Company. Achieve Healthcare, LLC ("Achieve Healthcare", "we", or "us") will use and maintain your personal, financial and medical information in a confidential manner in compliance with applicable state and federal laws. Sharing of this information with other health care providers or third-party payers such as health insurance providers, medical assistance, Medicare or other health programs may be necessary for the provision and payment of your care. A full description of how we may use and disclose your protected health information under the federal law known as HIPAA is included in our Notice of Privacy Practices, a copy of which is provided to you with this Authorization form. References in this document to "I", "my", "you", or "your" are to the above-named Consumer.

Assignment of Benefits and Responsibility for Payment: This allows us to bill your health plan and receive payment directly. It also means that you agree to pay for services not covered by your health plan.

- I authorize you to bill my health plan and third-party payers, directly on my behalf, and to receive direct payment of authorized benefits.
- I agree that it is my responsibility to pay for any healthcare services not covered by my health plan, including, but not limited to, co-payments, deductibles or co-insurance.

NOTE: Achieve Healthcare must agree to your request to restrict disclosure of your protected health information to your health plan if: (A) The disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (B) The protected health information pertains solely to a health care item or service for which you, or a person other than the health plan, has paid Achieve Healthcare in full. If you request this restriction please note the detail below:

☐ I do not wish to release information to the following Health Plan and I will pay for my care in advance in full to Achieve Healthcare.

Releasing Information for Care, Payment and Operations: This allows us to coordinate your care with other healthcare providers and to bill for services.

- I authorize the release of my applicable personal, financial, and medical information for treatment, payment, and healthcare operations and in compliance with the notice of privacy practices and applicable law.
- I authorize you to release information from my medical records for purposes of processing and paying claims, coordinating benefits, coordinating care, quality of care review studies, and other functions that support treatment, payment, and healthcare operations, including those functions that you are required by my health plan or other third-party payers to perform.
- I acknowledge that I have received, read, and understand the Notice of Privacy Practices for Achieve Healthcare.
- I understand that my medical information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse.

PLEASE SEE BACK OF PAGE FOR SIGNATURE AND DATE

- I understand this Authorization may be revoked by me, in writing, at any time, but would not apply to any information already released in good faith. A request for revocation or questions about disclosures may be sent to the Medical Record Department at the address listed above.
- I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure at which time the information may not be protected by federal privacy rules. I understand that once information is released as specified in this Authorization, Achieve Healthcare and its employees and providers cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.
- I understand that Achieve Healthcare may not condition treatment on whether I sign the authorization.
- I understand that I may inspect or copy the information used or disclosed, as provided in 45 C.F.R. 164.524.
- A photocopy/fax of this Authorization will be treated in the same manner as the original.
- This Authorization will remain in effect for one year unless earlier revoked.

Signed _____ Date _____
Consumer/Legal Guardian or Responsible Party

_____
(If not signed by Consumer, identify relationship to Consumer)