MDwise
A McLaren Company

Request for MDwise Medically Frail Assessment

Date: _____ Referring Facility: _____

Provider/Contact Person Phone: _____

Member Name: _____ Member RID: _____

Date of Birth: _____ Member Phone Number(s): _____

Diagnoses With Dates: _____

_____

_____

Inpatient Hospitalizations (Dates and Diagnoses): _____

_____

_____

Medications: _____

_____

_____

_____

Current Treatment Plan: _____

_____

_____

Please fax to MDwise Medically Frail Department at **844-407-6455**
or email to **MedFrailFax@mdwise.org**

In accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including but not limited to, 45 C.F.R. § 164.508; federal laws regarding the disclosure of alcohol and other substance abuse records, 42 C.F.R § 2, et seq.; and the State of Indiana's records laws pertaining to health records, and records relating to treatment for alcohol, substance abuse, and/or communicable disease(s), this form serves to obtain authorization to use and/or disclose information about your protected health information. The sharing of your health care information, including prescriptions and treatment recommendations, is essential for safe and effective coordination of your care.

Member Consent

By signing below, I authorize the following information to be shared with the individual(s) and/or health care organization(s) identified below in furtherance of my health care, and as determined by MDwise health care professionals and other MDwise employees. I further authorize that the above information may be disclosed to the extent needed to carry out and complete the purpose of the disclosure.

- Health records, including records relating to treatment, payment, and/or health care operations.
- Communicable Disease Records.
- HIV/AIDS Records.
- Substance Abuse Records.
- Alcohol Abuse Records.

I understand that I may revoke this authorization at any time by giving written notice to the organization that is authorized to release information. Unless I revoke this authorization in writing prior to this date, this authorization will expire upon the member's termination from the MDwise plan in which the member is enrolled. Pursuant to applicable law, the substance abuse records disclosed under this authorization may not be re-disclosed. Other records disclosed under this authorization however, may be re-disclosed by the recipient and may no longer be protected.

_____ _____

Signature of Member/Member's Designated Representative *Date*

Consent to Speak to Another Person

As discussed above, I give my consent for MDwise to speak to the following person(s) on my behalf about the matters and records, and to the extent addressed above.

_____ _____

Name *Relationship*

_____ _____

Name *Relationship*

Authorization for Release of Information to Other Health Care Organizations

As discussed above, I give my consent for MDwise to receive the information and records, and to the extent addressed above to the following health care organization(s).

_____

Name(s) and address(es) of Health Care Organization(s)

_____

_____