EDISON HEALTHCARE

PATIENT AUTHORIZATION FORM

EMPLOYEE NAME					
EMPLOYER / COMPANY NAME					
EMPLOYEE SOCIAL SECURITY NUMBER		EMPLOYEE DATE OF BIRTH			
EMPLOYEE HOME ADDRESS					
CITY		STATE		ZIP	
EMPLOYEE MOBILE PHONE		EMPLOYEE HOME PHONE			
EMPLOYEE EMAIL		EMPLOYEE FAX			

If the patient is a covered family member and **not the employee**, please share the following patient information:

PATIENT NAME					
PATIENT SOCIAL SECURITY NUMBER		PATIENT DATE OF BIRTH			
PATIENT HOME ADDRESS					
CITY		STATE		ZIP	
PATIENT PHONE		PATIENT EMAIL			

This section below is information about **your current local healthcare facility and physician**, both of whom may be contacted to obtain all necessary medical records, images and diagnostic information on your behalf.

CURRENT DIAGNOSIS					
PROPOSED PROCEDURE					
CURRENT HEALTHCARE FACILITY NAME					
SURGEON / SPECIALISTS NAME		OFFICE PHONE			
PRIMARY CARE PHYSICIAN		OFFICE PHONE			
PHYSICIAN ADDRESS					
CITY		STATE		ZIP	

PATIENT AUTHORIZATION FORM

ACKNOWLEDGEMENTS (By signing below, the patient acknowledges the following)

1. I hereby authorize my HEALTHCARE FACILITY, SURGEON, and PRIMARY CARE PHYSICIAN (all listed above) to share my private health information ("PHI") contained in my patient records with Edison Healthcare ("Edison") and its authorized representatives, including all SmartCare Centers, Medical Navigation Teams and Edison Care Coordinators. I understand and acknowledge that this may include treatment information for physical and mental illness, drug & alcohol abuse, and HIV/AIDS test results and diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes, as the release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record. This consent is subject to revocation at any time except to the extent that action has been taken and will expire one year from the date written below.
2. The employee and patient agree to abide by all requirements of Edison's program.
3. The employee's Company Health Plan is the "primary" medical insurance coverage for the above patient.
4. This program is designed for patients to have no co-payment or co-insurance costs for the approved procedure. If the patient is on a QHDHP plan type with an HSA, there may be deductible responsibilities(according to federal law). Patients with these plan types need to notify Edison so that Edison can handle this in advance.
5. If the patient chooses to have any additional health services while at an Edison SmartCare Center, not directly related to the approved procedure, they will be subject to the standard co-pays, co-insurance and deductibles for their Company Health Plan, or they may not be covered at all.
6. If any travel expenses or deductible costs paid on the employee's behalf by their employer have tax implications, they can inquire with their local HR team to discuss.
7. Billing & payment for all approved medical services will be submitted to Edison directly. The patient may be billed for any "non-medical patient convenience items". If the employee receives any medical billing information, they should reach out to their Care Coordinator to clarify. Also, no medical billing will be sent to the Company's insurance carrier unless it is determined that the employee does not qualify for the Edison program.
8. The employee/patient acknowledge that Edison't SmartCare Center will not begin formal evaluation of the patient for inclusion in the Edison program until they have received the patient's medical records and approval from Edison.
9. By signing below, the patient is providing approval for the Edison SmartCare Center to review the patient's medical records and to discuss medical treatment with the patient/representative.
10. The insured employee/patient consents to be contacted to participate in a confidential survey concerning their care, management, and overall experience with the Edison program after they return home.

SIGNATURE OF EMPLOYEE OR EMPLOYEE'S PERSONAL REPRESENTATIVE*

PRINTED NAME		DATE SIGNED	
RELATIONSHIP (IF SIGNED BY PERSONAL REPRESENTATIVE)*			

SIGNATURE OF PATIENT OR PATIENT'S PERSONAL REPRESENTATIVE* (*IF PATIENT IS NOT THE EMPLOYEE*)

PRINTED NAME		DATE SIGNED	
RELATIONSHIP (IF SIGNED BY PERSONAL REPRESENTATIVE)*			

* *If signed by a Personal Representative, a copy of the legal paperwork verifying the patient's personal representative MUST accompany this Medical Release (i.e. court appointed guardian, durable power of attorney for health care). Exception: if signed by a parent signing on behalf of their own child who is under the age of 18.*