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| **Wigs 360** | HIPAA Release of information |
| **380 Red Lion rd. Suite 237** | AUTHORIZATION FORM |

**Huntington Valley. PA 19006**

**Phone: 267 767 5608**

**Fax: 267 789 8017**

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

PRINT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB \_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby authorize Wigs 360 and its affiliates “Amoena”, my information relating to the diagnosis, treatment, claims payment, and care services provided or to be provided to me and which identifies (my name, address, Member ID number, etc.) for the purpose of helping me to resolve claims and health benefit coverage for Cranial Prosthesis.

Information to be released or exchanged include (check all that apply):

\_\_\_Member ID Card (front/back)

\_\_\_Aetna / Cigna Member Card (front/back)

\_\_\_Prescription (Cranial Prosthesis/ICD10)

\_\_\_Claim Authorization Form

I understand that I have a right to revoke this authorization by providing written notice to Wigs360. However, this authorization may not be revoked if Wigs 360, its employees, or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Signature of Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_