CONSENT FORM

Arise Administrators
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This form is used to obtain an individual's consent to allow a representative(s) of their choice to access the individual's protected health information for 30 months.

SECTION A: Individual Giving Consent.

Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Subscriber Number: _____ Social Security Number: _____

SECTION B: Consent – Please read the following statements carefully.

The following are representatives to whom I agree to permit Arise Administrators to disclose my protected health information. The nature of the disclosures includes but is not limited to payment issues, benefit determination, and coverage of services – unless restrictions are noted in Section C. I understand that Arise Administrators is not obligated to determine the legitimacy of a disclosure request made by a representative to whom I granted consent.

Representative: _____ Relationship: _____

Representative: _____ Relationship: _____

Representative: _____ Relationship: _____

SECTION C: Restrictions on Consent

You have the right to request that Arise Administrators restrict the nature of the disclosures made to the representatives you identified in Section B. Please indicate below any restrictions you on these disclosures.

_____

_____

SECTION D: Right to Revoke

You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your written notice of revocation.

SECTION E: Signature

I have had full opportunity to read and consider the contents of this form. I understand that, by signing this form, I am giving my consent for Arise Administrators to disclose my protected health information to the representatives identified above.

Printed Name: _____ Date: _____

Signature: _____