Understanding Benefits. Resolving Bills. Advocating for You.

HIPAA authorization

This authorization permits Coastal Healthcare Advocates ("CHA") and its representatives to communicate with your healthcare providers, insurance companies, and billing offices on your behalf so that we can review, research, and resolve the matters you have asked us to assist with.

01 Client information

Client full name

Date of birth MM/DD/YYYY

Address

Phone

02 Authorization

I authorize the healthcare providers, hospitals, insurance companies, pharmacies, and billing offices listed in this packet (or identified to Coastal Healthcare Advocates verbally or in writing) to:

- Discuss my protected health information (PHI), including medical records, billing records, claims, Explanations of Benefits (EOBs), itemized statements, account balances, and insurance coverage details, with Lindsey Hewitt and other authorized representatives of Coastal Healthcare Advocates.
- Release copies of records described above to Coastal Healthcare Advocates by phone, fax, mail, email, or secure electronic portal.
- Accept communications from Coastal Healthcare Advocates acting on my behalf, including requests for itemized bills, appeals, corrections, and billing disputes.

03 Scope and duration

This authorization covers all healthcare and billing matters for which I have engaged Coastal Healthcare Advocates, including past, current, and future dates of service related to those matters, unless I limit the scope below.

Limitations optional – leave blank if none

This authorization is valid from the date signed below until the earlier of (a) the date I revoke it in writing, or (b) one (1) year from the date signed, unless otherwise required by law.

04 Right to revoke

I understand that I may revoke this authorization at any time by submitting a written request to Coastal Healthcare Advocates, except to the extent that action has already been taken in reliance on this authorization. I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations (HIPAA).

I understand that Coastal Healthcare Advocates will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, as Coastal Healthcare Advocates does not provide medical treatment.

05 Signature

By signing below, I confirm that I have read and understand this authorization and voluntarily consent to the release and use of my protected health information as described above.

Client signature

Date MM/DD/YYYY

Printed name

Relationship to client
if signing on behalf of client