

Provider Consent for Treatment

Patient Last Name:	First:	MI:
Phone Number:		

Authorization for Release of Medical Information: I authorize Carelon, as my provider, to share my information: 1) with other healthcare professional and facilities for treatment purposes, such as managing or coordinating my care, and related services; 2) with my health plan and others as needed for payment purposes, such as eligibility and coverage determinations, billing, processing claims, coordinating benefits, utilization review and related functions; and 3) with others to improve the quality of my care and experience and to manage Carelon's business operations.

Assignment of Benefits: I authorize Carelon, as my provider, to bill my health plans direction on my behalf, and I assign payment of all insurance and health care benefits available to me directly to Carelon for the services provided to me.

Financial Responsibility: I understand and agree that I am financially responsible for payment of all charges which are not covered by my health insurance or health care benefits, including but not limited to copays, deductibles or co-insurance. I authorize the refund of overpaid insurance benefits where my coverage is subject to the coordination of benefits. In the event of default of many financial obligations owed by me, I agree to pay all costs of collections, including reasonable attorney's fees.

Authorization to Treat: I hereby consent to the medical care, examinations, and procedures determined by Carelon clinicians to be medically necessary for my treatment and discussed with me prior to delivery of such services.

I agree to receive communications via email and/or text, based on my preferences, for the following care related messages: appointment reminders; vaccine reminders and information; Annual Wellness Exam reminders; recommended screenings; and other healthcare and wellness information and services. I understand I can opt out at any time. Initials: _____

My consent will be valid for ten (10) years from the date that I give it. I may revoke my consent to share information in writing at any time. Revoking my consent doesn't apply to information that has already been shared. I understand that some uses and sharing of my information are authorized by law and do not require my consent.

For the purpose of my consent, "my information" means information that identifies me and relates to my health and services received, as further described in the Notice of Privacy Practices. Carelon's "Notice of Privacy Practices" has been made available to me at [carelon.com/nopp](https://www.carelon.com/nopp). It describes my privacy rights and additional disclosures my provider may make according to law.

Patient/Responsible Party Signature:

X _____