Request and Authorization for Release of Information

I understand that in order to assure the quality of services provided to me under my benefit(s) plan, information regarding my medical records, personal history (and/ or family's), reports of psychological test(s), medical diagnosis, plan and/ or treatment reports, may be confidentially reviewed by professionals within The Holman Group's Utilization Management Committee (UMC) and Quality Management (QM) Team.

I have discussed these procedures with ___________________________ who is authorized to provide relevant information to the Utilization Management Committee clinical representative. This confidential information will be used to assure the quality of service, review of payment for authorized services, and assure proper delivery of health care services. This information will not be used for any other purpose.

I understand that during and after counseling, I will receive a follow-up call and/or questionnaire from The Holman Group. The purpose of this follow-up will be to further assure that I received the assistance and/ or information requested.

I understand that this release of confidential medical information shall be valid for the period of my coverage under this group plan and that information obtained under this release will be used only for my treatment and determination of my benefits. The Holman Group will maintain the information provided for a period required by federal and state regulatory standards.

I understand that if I reveal information concerning child abuse, intent to harm myself or others, or abuse to the elderly, the therapist/ representative is mandated by law to report the information. All other maters will remain strictly confidential and privileged except for the purposes of professional review and follow-up.

I, the undersigned person, assume full personal financial responsibility for any psychological and counseling services rendered, other than the benefits which are contractually provided by The Holman Group.

I hereby authorize the payment of medical benefits to The Holman Group for services rendered to me.

I have received a copy of this Request for Authorization for Release of Information and hereby waive any additional reporting requirements governing notifications during the process of exchanging information between The Holman Group and my provider during my treatment.

I understand that a photocopy/ facsimile of this Request and Authorization shall be as valid as the original.

Requested By:	
	Dr. Maged Botros M.D., Medical Director

Enrollee Signature:		**Date:**	