CONFIDENTIALITY, PATIENT DELEGATE AND CREDIT REPORT AUTHORIZATION

I, _____, DOB: _____, residing at _____, authorize the use or disclosure of my confidential health information as described below:

1. AUTHORIZED PERSONS TO USE AND DISCLOSE CONFIDENTIAL HEALTH INFORMATION

I direct you, as a health care provider, a provider of services, a provider of medical or health services, and any other person or organization who furnishes, bills for, or is paid for my health care, or the health care of a person for whom I am legally responsible, in the normal course of business, to disclose and communicate the following confidential health information to **Advanced Medical Pricing Solutions, Inc. ("AMPS") and its subsidiaries of 2700 N. Central Avenue, Suite 1400, Phoenix, Arizona 85004; (855) 201-1508; solidarity@amps.com.**

2. DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information that may be disclosed is:

Medical records
Communicable diseases (including HIV and AIDS)
Alcohol/drug abuse treatment
Mental health records
All treatment records
Other: any and all records requested by AMPS

All past, present, and future periods of health care information may be shared.

3. PURPOSE OF THE USE OR DISCLOSURE

The purpose of this use or disclosure is for medical care navigation, the review of charges for my treatment/care for appropriateness and to respond on my behalf to any dispute associated with the same.

4. PATIENT DELEGATE AUTHORIZATION

I appoint AMPS as my Patient Delegate and authorize it to act on my behalf as my representative and agent in dealing with any charges for treatment, care and services provided to me or to a person for whom I am legally responsible. All correspondence and/or communications pertaining to these matters should be directed to AMPS at the address listed in Section 1 above.

5. PERMITTED PURPOSE OF CREDIT REPORTING

I further authorize AMPS to procure a consumer report pursuant to Section 604(a)(3)(F) of the Fair Credit Reporting Act, and I authorize the credit reporting agency ("CRA") to furnish my credit report to AMPS upon request. I understand that my signature, including my electronic signature, is an acceptable method of authorizing the provision to AMPS of my consumer report under the Fair Credit Reporting Act.

6. VALIDITY OF AUTHORIZATION FORM

This authorization shall be effective for all past, present, and future periods during which I receive, or have received, care and treatment until revoked. Unless and until I specifically revoke this authorization, it shall remain valid and effective for as long as any portion of medical care navigation or my obligation of payment remains unsettled.

7. ACKNOWLEDGMENT

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it. I understand that my treatment will not be conditioned on whether I sign this authorization.

I acknowledge that I have the right to refuse to sign this form. If signed, I retain the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

By: _____ Date: _____
Patient Signature

_____
Printed Name of Patient

By: _____ Relationship to Patient: _____
Signature of Parent/Guardian if Patient is unable to sign

The electronic signature above is legally equivalent to a handwritten signature and is valid and legally binding on all parties. Copies or facsimiles of this authorization shall be as valid as the original release.