Partners Community Access Program

Application for Primary Care Benefits

Put your clinic name here!

Name: _____ _____

First Middle Initial Last Social Security Number

ENROLLMENT, AUTHORIZATION AND RELEASE

I wish to enroll in the Community Access Program (CAP) sponsored by Partners in Health Network, Inc. The services of CAP have been explained to me in detail and the questions I have about CAP have been answered.

I am asking for admission or treatment by the health care provider recommended by the clinic and its employees, agents, medical staff, certified physicians and or/or physician group practices. I understand these providers are **separate,** but they are cooperating in a program called **Partners Community Access Program and that they may share information about me with Partners or its agents.**

I understand that if I am qualified, Partners Community Access Program may help me in getting care at reduced rates. In order to speed up the processing of my application, I give permission to the health care provider recommended, to release information or records which they may have concerning me to the Partners Community Access Program or to any other provider participating in the Partners Community Access Program. Information that may be released includes my medical records, other information about my health care and financial information. This information will be kept confidential. My medical record information shall be available only to the appropriate individuals on a **need to know** basis. I may withdraw this permission at any time for any reason.

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I have read this Authorization and Release (or it has been read to me) and I understand the permission, which I am granting by signing this document. I understand that I have the right to see and copy any written information to be shared. I understand that I have the right to receive a copy of this form. A copy of this Authorization shall be considered an original copy.

This authorization and release shall be valid continuously from the date of signature, unless properly withdrawn by either party to this agreement.

I hereby certify that the financial information given by me is correct to my best knowledge and belief. I understand that the discount payment is expected at the time of service. I agree to provide updated information if I obtain health care insurance or my household income changes.

Enrollee signature: _____ **Date:** _____

Witness Name & Signature: _____ **Date:** _____