SHARP, Inc.

St. Bernard's Medical Center

Narcotic Continuation Appeal – Patient Consent Form

Patient Name : _____

Date of Birth: _____

Member ID Number: _____

Stated Purpose for this release: SHARP, Inc. will communicate with my physician regarding my Protected Health Information, specifically pursuant to processing this Narcotic Continuation Appeal for continued medical benefits under my plan coverage through St. Bernard's Medical Center.

I hereby give my consent to SHARP, Inc. to communicate with my physician, and for my physician to disclose my medical information to SHARP, Inc., during the period from: effective the date I sign below to date of completed appeal response to me.

_____

Name of Physician

As the recipient of my Protected Health Information, SHARP, Inc. is prohibited from using this information for any other purpose other than the stated purpose.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Authorized Representative **Relationship**

SHARP, Inc

St. Bernards Medical Center

Narcotic Continuation Appeal Form

Patient Name: _____

Address: _____

_____

Employee Name: _____

Patient Date of Birth: _____

Prescribing Physician: _____

Physician Address: _____

_____

Phone Number: _____

PATIENT'S DESIRED NOTIFICATION OF DECISION BY:

Secure email _____or

Secure fax number _____or

Mailing address _____

Items required for appeal:

1) Patient's medical record
2) Patient's signed consent to communicate with physician regarding patient's protected health information
3) Letter from physician stating diagnosis and reason for continuation for drug use
4) Patient's desired notification of decision by: secure e-mail, secure fax number or mailing address

Fax or mail to: SHARP, Inc.
ATTN: Medical Management – N.A.
P.O. Box 7097
Jonesboro, AR 72403
(870) 972-0036 (Fax)