CSL Behring

My Source[SM]*: Patient Release Form*

P.O. Box 4133
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Phone: 1-800-676-4266
Fax: 1-844-727-2757

Patient Information:

Patient Name: ______________________________

Date of Birth (m/d/y): __________ SS # (last 4 digits): ______________

Address: ______________________________

City: ______________ State: __________ ZIP: __________

Phone Number: ______________ Male____ Female ____

Insurance Information:

Primary Insurance Company: ______________ Phone Number: __________

Policy Number: ______________ Group Number: __________

Policy Holder Name: ______________ Policy Holder Date of Birth: __________

Secondary Insurance Company: ______________ Phone Number: __________

Policy Number: ______________ Group Number: __________

Policy Holder Name: ______________ Policy Holder Date of Birth: __________

Physician Information:

Physician Name: ______________ Phone Number: __________

Clinic Name: ______________ Clinic Contact: __________

The information on this form is accurate and complete. I hereby authorize my healthcare providers, health plans, and insurers to release medical and other pertinent information to Covance Market Access Services and/or its authorized designee for the sole purpose of determining medical insurance benefits.

Patient's Signature: ______________ Date (m/d/y): __________
(or Legal Guardian)

Confidentiality:

Confidentiality related to patient information is of utmost importance. Representatives of **Covance Market Access Services and/or its affiliate companies** and the aforementioned healthcare provider, by recognition of this form, state their compliance with federal, state, and local guidelines regarding patient confidentiality rights.

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