Total Scholastic Solutions

Medical Release Form

Please send the completed form to ClaimsAssist@TSSAssist.com or via Fax at +1.949.271.2330.

A. PATIENT INFORMATION	
Name (Last, First, MI):	
Policy #:	Member ID #:
Date of Birth: (DD/MMM/YYYY, i.e., 23/NOV/1988)	
Address:	
Postal Code:	Country:
Phone:	Fax:
Email:	

B. AUTHORIZATION

I hereby authorize any physician or other healthcare professional, hospital or healthcare-related facility, pharmacy, medical service provider, employer, benefit plan administrator, and any Federal, State or Local Government Agency, with a complete copy of any and all medical information for use and disclosure as described in this authorization. Further, to release any medical and other information in your possession or control to Total Scholastic Solutions and/or their attorneys, either directly or through a representative agent acting on their behalf, any and all medical information they may request, including but not limited to, medical records, reports, charts, graphs, notes x-rays, films, and laboratory reports.

I also hereby authorize the release of all medical information regarding diagnosis, care and treatment for alcohol abuse, drug abuse or mental health. In addition, I authorize the release of any and all billing records and statements in your possession or control.

I also authorize Total Scholastic Solutions, its representatives or their agents, to release information that is obtained pursuant to this authorization to providers of healthcare, insurers, re-insurers, or claims administrators, and any government agency as it deems appropriate solely for the purpose of evaluating and administering any claim for benefits. I further understand that information may be released as follows:

- To other persons or organizations performing business or legal services in connection with any claim;
- As may be otherwise lawfully required;
- To any person or legally authorized representative as I have so indicated; please indicate name/s of authorized representatives:

  _____
- As I may further authorize; or as necessary to prevent or detect the perpetration of fraud.

This "Authorization For Release of Information" is subject to revocation at any time except to the extent that action has been taken in reliance hereon and, if not earlier revoked in writing, it shall remain valid for two (2) years from date of signature. I agree that a photocopy, e-mailed copy or facsimile (FAX) copy of the authorization shall be accepted and as valid as the original. I know that I may request to receive a copy of this Authorization.

Insured Person	**Parent or Duly Appointed Legal Guardian** Note: Please attach proof of legal guardianship/conservatorship, etc.
Name:	Name:
Signature: By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.	Signature: By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.
Date:	Date:

Privacy Notice

The Total Scholastic Solutions group of companies includes brokering and management companies, as well as assistance and administration companies. We respect your privacy, and we are all committed to protecting your personal information.

Our privacy policy tells you about your privacy rights and how the law protects you. This includes information on how we collect and then process your personal information. Our privacy policy is located on our website at www.totalscholasticsolutions.com/privacy-policy and we would advise you to read the policy so you understand your rights and your personal data use by the TSS Group.