

ASC Customer Service

MAGNACARE
CONSENT TO USE, DISCLOSE OR ACQUIRE
CONFIDENTIAL HEALTH INFORMATION

By signing this form, I agree on behalf of (check one) ☐ myself ☐ my minor children/dependents,
that MagnaCare and its affiliates and its employees and agents may use or disclose to
_____ (check one) ☐ my/ ☐ my minor children(s)/dependent(s)

Enter name of the person who you designate as your personal representative

confidential health and other individually identifiable information for the purposes of treatment,
payment or health care operations, as those terms are explained in MagnaCare's Notice of
Information Privacy Practices. My consent includes my agreement for the use or disclosure of
confidential health information that may include diagnosis, prognosis, treatment and payment
information related to physical and/or mental illness, including, but not limited to: substance
abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC), human
immunodeficiency virus (HIV), communicable diseases or genetic conditions.

Patient Name: _____

Primary Member Name: _____

Patient Signature: _____

Primary Member ID No: _____

Home address: _____

Home Telephone: _____

Date: _____

Employer/Fund: _____

Minor Child(ren)/Dependent(s)' name(s), when applicable:

