Acumen Fiscal Agent
Innovation • Opportunity • Freedom

Please return form to NCMCOAgents@acumen2.net

AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

Participant's Name_____ Participant's Medicaid ID_____

Employer Name _____

I voluntarily give my consent to allow Acumen Fiscal Agent to receive information from and/or release private (confidential) to the following person and/or entity as it specifically relates to the NC Innovations Waiver and the above-mentioned participant.

Name/Entity: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax#: _____

- I understand this authorization is in place indefinitely until otherwise communicated.
- I know that I may change my mind about releasing information. If I do so, I must withdraw my authorization by contacting Acumen and signing a "Withdrawal of Authorization to Obtain-Disclose Protected Health Information".
- I understand that Acumen Fiscal Agent will disclose the minimum amount of information necessary to accomplish the indicated purpose(s).
- I understand that I may refuse to sign this authorization and that refusal alone will not affect my ability to obtain services.
- This Authorization will become null and void if the client withdraws from Acumen as their Fiscal Management Agency.
- This form has been explained to me in a way that I understand.
- I have been allowed to ask questions about this process.

_____ _____

Employer Signature Date

_____ _____

Participant Signature Date
(if applicable)