RIDDLE CARE NAVIGATION
& FINANCIAL ADVOCACY

Riddle Care Navigation & Financial Advocacy, LLC
Boerne · Fair Oaks Ranch · Texas Hill Country
(210) 201-3253 · tamara@riddlehealthcare.com

Patient Advocate Authorization

AUTHORIZATION TO COMMUNICATE AND ACT ON THE PATIENT'S BEHALF

I authorize the advocate named below to represent me as my patient advocate. This means the advocate may communicate with my healthcare providers, facilities, pharmacies, and insurers, and take the actions I approve in Part 4. Please give a copy of this form to any organization that asks for proof of my permission.

> **Please also sign the Texas HIPAA Authorization**
>
> This form explains what your advocate may do for you. The Texas HIPAA Authorization to Disclose Protected Health Information is a separate records release that doctors's offices and hospitals in Texas recognize and accept. Signing both helps prevent delays when we request your records. Both forms are on our New Clients page.

Part 1. Patient Information

Patient name: _____

Date of birth: _____ Phone: _____

Address: _____

Email: _____ Medicare or member ID (optional): _____

Part 2. Advocate Designated

Organization: Riddle Care Navigation & Financial Advocacy, LLC

Advocate: Tamara Riddle, Owner and Patient Advocate, and staff working under her direction

Professional status: Independent, non-clinical healthcare navigation and financial advocate (not an attorney)

Phone and email: (210) 201-3253 · tamara@riddlehealthcare.com

Mailing address: _____

Part 3. Organizations Covered

This authorization applies to the organizations checked below (check all that apply):

☐ All of my doctors, hospitals, clinics, care facilities, home health and hospice agencies, and pharmacies

☐ All of my health plans, including Medicare, Medicare Advantage, Medicaid, commercial, supplemental, and long-term care insurance

☐ VA healthcare (VA may also require VA Form 10-5345)

☐ Only the specific organizations listed here:

_____

_____

Part 4. What the Advocate May Do

Please initial each item you approve. Leave blank anything you do not approve.

The advocate may:	Initials
Speak with and receive information, verbally, in writing, or electronically, about my care, coverage, claims, and bills	_____
Obtain copies of my medical records, itemized bills, explanations of benefits, claim and payment records, denial letters, and plan documents	_____
Attend care team meetings, discharge planning meetings, and appointments with me or for me, in person, by phone, or virtually	_____
Coordinate scheduling, transfers, discharge plans, home health, hospice, and related services	_____
Request itemized bills, dispute billing errors, and negotiate charges and payment arrangements (any final agreement requires my written approval)	_____
Request prior authorizations, file grievances, and prepare and submit appeals on my behalf, where the organization allows	_____
Apply for financial assistance, charity care, prescription assistance, and benefit programs on my behalf	_____
Share updates with my attorney and the family members or other people listed below	_____

People the advocate may share updates with (name, relationship, phone):

1. _____

2. _____

3. _____

Part 5. Information That May Be Shared

Unless I mark otherwise, this includes all of my health, billing, insurance, and claims information related to the purposes above. The following sensitive information may be shared only if I initial it:

_____ Mental health records (not including psychotherapy notes)

_____ Drug, alcohol, or substance use treatment records (some programs require their own consent form)

_____ HIV/AIDS testing and treatment

_____ Genetic information, including genetic test results

Part 6. Limits of This Authorization

This authorization does not allow the advocate to:

- Make medical decisions or consent to treatment for me (that requires a Medical Power of Attorney or other legal authority)
- Accept a settlement, payment plan, or other binding agreement for me without my written approval
- Access, manage, or spend my money, bank accounts, or benefits
- Give medical or legal advice, or represent me in court

Part 7. How Long This Authorization Lasts

This authorization begins on the date I sign it and ends on the earliest of: (a) one year after the date I sign it; (b) the end of my service agreement with Riddle Care Navigation; (c) the date I revoke it in writing; or (d) this date, if I choose one:

Specific end date (optional): _____

I may revoke this authorization at any time by giving written notice to Riddle Care Navigation and to the organizations that have a copy. Revoking it does not affect actions already taken in reliance on it. A copy, scan, or electronic version of this signed form is as valid as the original.

Part 8. Your Rights

- Signing this form is voluntary. My treatment, payment, health plan enrollment, and eligibility for benefits do not depend on whether I sign it.
- Information shared under this authorization may be shared again by the person receiving it and may no longer be protected by federal or state privacy law.
- I have the right to receive a copy of this signed form.
- Riddle Care Navigation keeps my information confidential and uses it only to provide the services I request, as described in its Practice Policies.

Signatures

By signing, I confirm that I have read this form, understand it, and authorize the advocate as described above.

Patient

Signature: _____ Date: _____

Printed name: _____

Legal Representative (if signing for the patient)

Signature: _____ Date: _____

Printed name: _____

Authority (check one):

☐ Agent under a Medical Power of Attorney

☐ Agent under a Durable (Financial) Power of Attorney (billing and insurance matters only)

☐ Court-appointed guardian

☐ Parent of a minor

☐ Executor or administrator of the estate (patient deceased)

☐ Other: _____

Please attach a copy of the document showing your legal authority.

Note for attorneys: Representing the patient as their attorney does not, by itself, give authority to sign this form. An attorney may sign only if they also hold one of the roles listed above. Otherwise, the patient or their legal representative signs, and the attorney may receive information through a separate HIPAA authorization.

Acceptance by Advocate

I accept this designation and agree to act within the limits described above.

Signature: _____ Date: _____

Tamara Riddle, Owner and Patient Advocate, Riddle Care Navigation & Financial Advocacy, LLC

Also Required: Texas HIPAA Authorization

Please sign the Texas standard HIPAA Authorization to Disclose Protected Health Information along with this form. It is a separate records release that doctors' offices, hospitals, and other Texas providers recognize, and many prefer it when sending medical records. It is available on our New Clients page, and we are happy to help you fill it out.

☐ I have also signed the Texas HIPAA Authorization.

Patient initials: _____

Important: Some Organizations Use Their Own Forms

Many organizations accept this authorization. Some require their own form before they will speak with an advocate or accept an appeal. We will help you complete any of these:

- **Medicare appeals and grievances:** Appointment of Representative, Form CMS-1696
- **1-800-MEDICARE:** Authorization to Disclose Personal Health Information, Form CMS-10106
- **VA health records:** VA Form 10-5345
- **Social Security disability (SSDI):** Appointment of Representative, Form SSA-1696
- **Private insurance plans:** the plan's own authorized representative or release form

---

Please return the signed form through the secure client portal at app.carepatron.com. Keep a copy for your records.