mosaic health
Better happens together.

For Internal Use Only: _____
Signature of Mosaic Health Staff receiving completed form
Patient Account Number: _____ _____
Date

Authorization for Care Coordination Communication

Patient Name:_____Date of Birth: _____
Address:_____Phone Number: _____

Communication for care coordination between:

Mosaic Health **and:**

Provider/Practice/Organization Name: _____
Address:_____
Phone number: _____

I authorize Mosaic Health staff to engage in all modes of communication and/or to leave a detailed message with the practice or organization(s) identified above for the following purposes:

- □ All aspects of my care treatment and payment, including insurance, benefits and claims
- □ All clinical care, including test results and visit documentation
- □ All billing and insurance information
- □ Schedule, cancel, reschedule or obtain information about my appointments
- □ Other (Describe): _____

Specific authorization is required to share the following information. For each item below, initial where indicated:

_____Substance Abuse Records _____HIV Related Records

_____Psychiatric, Mental Health or Behavioral Health Records

Conditions of Authorization:

1. I understand that this consent is limited to information necessary for care coordination.
2. I understand communication may consist of verbal, email, fax, or mail between Mosaic Health and listed Providers/Organizations.
3. I understand that I am fully responsible for reporting changes to data or named practices/organizations.
4. I understand that this authorization may be revoked in writing at any time by contacting Mosaic Health, but this will not affect any information already shared.
5. This consent is valid:
   - As long as I am a current patient at Mosaic Health or until _____ (date or event).

_____ _____
Signature of Patient or Legal representative Date Signed

_____ _____
Printed Name of Patient or Legal Representative Legal Representative Relationship to Patient

☐ **Mount Morris**
1 Murray Hill Drive
Building 1, Room 140
Mt. Morris, NY 14510
P:585-243-7840
F: 844-683-9216

☐ **Rushville**
2 Rubin Drive
Rushville, NY 14544
P: 585-554-4400
F: 844-683-9216

☐ **Utica-Medical**
1651 Oneida Street
Utica, NY 13501
P: 315-793-7600
F844-683-9216

☐ **Utica-Dental**
3 Parkside Court
Building 1
Utica, NY 13501
P: 315-293-7600
F: 844-683-9216

☐ **Lyons**
1519 Nye Road
Lyons, NY 14489
P: 315-871-3178
F: 844-683-9216

☐ **Ilion**
55 Central Plaza,
Suite B
Ilion, NY 13357
P: 315-444-1900
F: 844-683-9216