SCOTTSBORO ELECTRIC POWER BOARD

MEDICAL FORM FOR CERTIFICATION OF USE OF LIFE – SUSTAINING ELECTRIC DEVICE

Patient Name: ____

Patient Address: ____

Medical Authorization

Physician is hereby authorized to furnish to Scottsboro Electric Power Board (SEPB), 404 E Willow Street, Scottsboro, Alabama, 35768, and any and all information in your possession concerning the undersigned patient's physical condition, care, diagnoses, and treatment. The undersigned patient understands that treatment, payment, enrollment, or eligibility for benefits has not been conditioned on the signing of this authorization. The undersigned patient further waives all privileges and confidentiality, which may exist in the doctor/patient relationship or healthcare provider/patient relationship, so as to permit the release of all information desired by SEPB. The undersigned patient further releases you and all other persons employed by you for all claims the undersigned patient may have or claim to have for any invasion of privacy by reason of your furnishing information to SEPB. The undersigned patient, further states that this medical authorization is to be considered by you to contain the core elements and required statements outlined in 45 CFR, Section 164.500, et seq. to allow you to disclose the requested information with SEPB in compliance with the HIPPA Privacy Standards with respect to the disclosure of protected health information.

Date: _________________ Patient Signature______________________________

Sworn to and subscribed before me, on this ______ day of ____________, 20____.

Notary Public: _________________________ My Com. Expires __________ (SEAL)

PHYSICIAN: PLEASE COMPLETE ALL PARTS. SEPB WILL CALL TO CONFIRM.

I am a licensed physician in the State of _____________________. The above named customer is a patient of mine and in under my care and treatment at this time. I have personally examined the above named patient within the past 90 days. The above named patient is suffering from the following medical condition____

The above medical condition requires the patient to use the following electric life sustaining device.____

In my opinion the termination of electrical service at the present time would result in an immediate life threatening condition for the above patient. My opinion is based upon a reasonable degree of medical certainty.

Physician Signature: _____________________________________ Phone Number: ________________

Print Physician Name: ___________________________________ Date: _________________________

Date: _________________ Patient Signature______________________________

Sworn to and subscribed before me, on this ______ day of ____________, 20____.

Notary Public: _________________________ My Com. Expires __________ (SEAL)

Customer's Acknowledgement

I have been informed by SEPB that this is only a temporary extension to pay my account and if my condition remains the same or worsens, then it is my responsibility to renew this form on or before 180 days. I acknowledge that it is my responsibility during this period to arrange for the transfer of the above patient to another location, in the event payment cannot be made.

I have been informed by SEPB that SEPB has the sole discretion to accept or deny this application for relief based upon a life threatening condition for the above named patient.

Date: _________________________ Customer Signature: _______________________________

Form M – Office Use Only – Account # ____________________________ Date Received: ______________