moms2b

a maternity CarePath product™ by StrykeFox Medical

Permission to Share My Records

Your signed permission lets your provider's office send us the records your insurer needs. (A HIPAA authorization under 45 CFR 164.508 — sign & return with your intake forms.)

YOUR NAME (PRINT) _____ **DATE OF BIRTH** _____

ADDRESS _____ **PHONE** _____

I give the provider and practice named below — and their team — my permission to share my protected health information with **StrykeFox Medical LLC** (moms2b), 9225 W. Charleston Blvd., Suite 2134, Las Vegas, NV 89117, Fax (775) 476-2052 — so it can obtain, deliver, bill, and obtain reimbursement for the equipment and supplies ordered for my maternity care, and coordinate that care with my provider.

PROVIDER / PRACTICE THAT MAY SHARE MY RECORDS

_____

What they may share (check all that apply)

- ☐ Prenatal and obstetric records for this pregnancy
- ☐ Most recent visit / progress notes and face sheet (demographics)
- ☐ Insurance cards and coverage information on file
- ☐ Laboratory and imaging results relevant to my ordered equipment
- ☐ Delivery and postpartum records relevant to my ordered equipment
- ☐ Other: _____

How long, and your rights

This permission expires **24 months from the date I sign below**, unless I end it sooner. I may end it at any time with a written note to StrykeFox Medical LLC at the address above; ending it won't undo anything already shared in reliance on it. I understand that information shared under this permission may be re-shared by the recipient and may no longer be protected by HIPAA, and that my treatment, payment, enrollment, or eligibility for benefits will never depend on whether I sign. I am entitled to a copy of this signed permission.

SIGNATURE _____ **DATE** _____

If a personal representative is signing, print name, relationship, and authority:

_____

FOR THE PRACTICE — A LITTLE RECEIPT FOR YOUR FILES

Date sent: _____ Sent by: _____ Pages: _____ Method: ☐ Fax ☐ Mail ☐ Portal