CONSENT TO DETERMINE ELIGIBILITY FOR COBRA BENEFITS

Patient's Name: ____

Last **First** **Middle**

Home Address: ____

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Home Telephone: ____________________ Date of Birth: ______________

SPECIFY INFORMATION TO BE DISCLOSED: **The information that may be disclosed under this Consent shall be limited to information that may be necessary to determine your eligibility for health insurance coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), including the fact that you have received, or are currently receiving, health care services from [ORGANIZATION].**

RECIPIENT: **The parties to whom [ORGANIZATION] may disclose the limited information described above include: ____**

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____.

PURPOSE: **[ORGANIZATION] will be disclosing the limited information described above in order to determine your eligibility for health insurance coverage pursuant to COBRA, under which covered employees and their qualified beneficiaries have the opportunity to purchase continued health insurance coverage under company health and dental plans for specified periods of time when a "qualifying event" would normally result in the loss of eligibility.**

I have read and understand the terms of this Consent and I have had an opportunity to ask questions about this disclosure of my health information. By my signature, I hereby, knowingly and voluntarily consent to [ORGANIZATION] disclosing my information, as described above.

______________________________ ______________

Signature of Patient **Date**

Note: If Patient is a minor or is otherwise unable to sign this Consent, obtain the following signatures:

______________________ ______________ ______________

Signature of Authorized Personal Representative — Relationship to Patient — Date