LIMITED POWER OF ATTORNEY TO PURSUE PAYMENT AND APPEALS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

By signing this document, you give the Hospital the limited power to pursue appeals with and to seek payment from your health insurer, health maintenance organization, or other payor ("Health Plan") for health care services provided to you by the Hospital, and you authorize the release of medical information.

I, _____, residing at _____, appoint Calvary Hospital, located at 1740 Eastchester Rd. Bronx, NY 10461, to be my attorney-in-fact and authorized representative to act on my behalf and to take all reasonable actions, as determined by the Hospital, to pursue payment from my Health Plan and /or to pursue any appeals available to me under my Health Plan's policies or procedures and/or under applicable law, including but not limited to external appeals in accordance with New York State and federal laws, relating to health care services provided by the Hospital. The Hospital will not charge me for its services in pursuing these appeals. If the Hospital pursues and wins these appeals, I agree that my Health Plan will pay any monies owed directly to the hospital for these health care services.

In pursuing such payment and/or appeals:

A. I authorize the Hospital and my Health Plan to release all relevant medical information, including (if applicable) any human immunodeficiency virus-related information, mental health treatment information or alcohol /substance abuse treatment information relating to my treatment necessary to pursue payment from my Health Plan. I understand that this information may be released, but only as necessary to an external appeal agent, arbitrator, court of law or other independent third-party reviewer responsible for deciding if a claim must be paid ("Independent Reviewer"). I understand that the Independent Reviewer will use this information to make a decision about payment and/or an appeal. This authorization for the release of my medical records is valid for one year from the date the authorization is signed by me or the Hospital as my attorney-in-fact; and

B. I authorize the Hospital to complete, to execute, to acknowledge, to seal and to deliver any consent, demand, request, application, agreement, authorization or other documents necessary, including but not limited to, request an appeal with my Health Plan and/or an external appeal with the New York State Department of Health Plan and/or an external appeal with the New York State Department of Health, Insurance Department, U. S. Department of Labor and/or other applicable agency or body.

This Limited Power of Attorney and Authorization shall not be affected by my subsequent disability or incompetence and may be revoked by me at any time upon written notice to the Hospital

IN WITNESS WHEREOF, I have hereunto signed my name this _____, day of _____, 20____.

YOU SIGN HERE _____

WITNESS: _____

PRINT NAME/TITLE: _____

ADDRESS: 1740 Eastchester Rd. Bronx, NY 10461

TELEPHONE: (718) 518-2000