Consent for MESSA Medical Case Management

I agree to participate in the MESSA Medical Case Management program. To assure appropriate medical case management services, I _____ authorize any physician, hospital or other professional involved in my treatment to disclose medical, hospital, vocational or related information. I authorize that the information may be shared with other professionals, agencies, or insurance companies who may be involved in the provision or payment of necessary services.

A copy of this authorization may be accepted, if necessary. This consent and authorization will remain in effect until such time as case management services are discontinued or I notify MESSA in writing that this authorization is no longer valid.

Please mail this form to:

MESSA Medical Case Management
1475 Kendale Blvd.
East Lansing, MI 48823

or fax it to: 517.203.2998

Signed _____ Date _____

Guardian _____ Date _____
(If applicable)

Witness _____ Date _____