CLIENT APPROVED CONTACT AUTHORIZATION

Fax Completed Form to 413-668-0022 or e-mail to support@mailchs.com

Date: _____

Client Name: _____

I authorize the following staff/employees to be added as authorized "contacts" for the purpose of *obtaining support services* from CHS.

Please include name (first and last) and e-mail address if applicable.

_____

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I understand that my authorization will remain effective from the date of my signature until I notify CHS of a change, and that the information will be handled confidentially in compliance with all applicable HIPAA/ Security laws.

I understand that I may revoke this authorization at any time by written, dated communication.

I have read and understand the nature of this release.

_____ _____

Client Name / Title Date:

_____ _____

Acknowledged by Complete HealthCare Solutions, Inc. Date:

Client Account Contact Updated on_____(for CHS Purpose only)