

MEDICAL FORM FOR CERTIFICATION OF USE
OF LIFE-SUSTAINING ELECTRIC DEVICE
OFFICE USE ONLY

Account #: _____ Account Name: _____
Date Received: _____

PATIENT NAME: _____

PATIENT ADDRESS: _____

Medical Authorization

Physician is hereby authorized to furnish to Forked Deer Electric Cooperative, 1135 N. Church St., Halls, Tennessee 38040, any and all information in your possession concerning the undersigned patient's physical condition, care, diagnoses, and treatment. The undersigned patient understands that treatment, payment, enrollment, or eligibility for benefits has not been conditioned on the signing of this authorization. The undersigned patient further waives all privileges and confidentiality, which may exist in the doctor/patient relationship or healthcare provider/patient relationship, so as to permit the release of all information desired by Forked Deer Electric Cooperative (FDEC). The undersigned patient further releases you and all other persons employed by you for all claims the undersigned patient may have or claim to have for any invasion of privacy by reason of your furnishing information to FDEC. The undersigned patient further states that this medical authorization is to be considered by you to contain the core elements and required statements outlined in 45 CFR, Section 164.500, et seq. to allow you to disclose the requested information with FDEC in compliance with the HIPPA Privacy Standards with respect to the disclosure of protected health information.

Date _____

Patient

Sworn to and subscribed before me, on this the _____ day of _____, 20____

Notary Public: _____ My Com. Exp. _____

(SEAL)

PHYSICIAN: PLEASE COMPLETE ALL PARTS. FORKED DEER ELECTRIC WILL CALL TO CONFIRM.

I am a licensed physician in the State of _____. The above named customer is a patient of mine and is under my care and treatment at this time. I have personally examined the above named patient within the past 90 days. The above patient is suffering from the following medical condition:

(Type or Print)

The above medical condition requires the patient to use the following electric life-sustaining device:

(Type or Print)

In my opinion the termination of electrical service at the present time would result in an immediate life threatening condition for the above patient. My opinion is based upon a reasonable degree of medical certainty.

Physician Signature

Print Name

Phone Number

For Office Use Only

CUSTOMER'S
ACKNOWLEDGEMENT

I have been informed by Forked Deer Electric Cooperative that this is only a temporary extension to pay my account and if my condition remains the same or worsens, then it is my responsibility to renew this form on or before **180** days. I acknowledge that it is my responsibility during this period to arrange for the transfer of the above patient to another location, in the event payment cannot be made.

I have been informed by Forked Deer Electric Cooperative that Forked Deer Electric Cooperative has the sole discretion to accept or deny this application for relief based upon a life threatening condition for the above named patient.

_____ Date

_____ Customer Signature

Sworn to and subscribed before me, on this the ____ day of _____, 20____

Notary Public: _____ My Com. Exp. _____

(SEAL)