

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Aging and Adult Administration
State Health Insurance Assistance Program

CLIENT AGREEMENT AND AUTHORIZATION

The following understandings and assurances have been explained to me and I agree to counseling under provisions and guidelines of the Arizona State Health Insurance Assistance Program or an affiliated program operated by an Area Agency on Aging in Arizona.

- These programs are non-profit and are intended to provide information regarding Medicare, Medigap, long term care, Medicare +Choice, Arizona Health Care Cost Containments System (AHCCCS) other benefits programs and other health and long term care options.
- Services are provided by trained volunteer counselors, who are acting in good faith, and information given shall not be construed to be legal advice.
- Counselors do not sell, recommend or endorse any specific insurance product, agent, company, or Medicare +Choice Plan, nor may they be actively affiliated with the insurance or financial planning industry. Any potential conflict of interest will be clearly disclosed to me.
- Counselors assume no responsibility for decisions made or actions taken by me and I hold harmless the Arizona State Health Insurance Assistance Program, Area Agency on Aging and the counselor for any liability arising out of services provided within the program guidelines.
- Counselors will use information only in pursuit of assisting the clients and will not divulge confidential data to external sources other than Medicare, service providers or insurance carriers in conjunction with counseling or assistance duties.

I hereby authorize the program and or the below named individual to receive and transmit information as necessary from/to my hospitals, physicians and/or other providers of medical services or supplies as well as Medicare Carriers and Intermediaries and my private insurance companies. Unless restricted below, this authorization shall remain valid for 365 days from the date of signature and shall apply to all claims filed on my behalf in the past, present or future.

BENEFICIARY'S NAME	MEDICARE ID NO.
COUNSELOR'S NAME	CLAIM NO.
INFORMATION TO BE RELEASED <input type="checkbox"/> One Time <input type="checkbox"/> Ongoing <input type="checkbox"/> Claim <input type="checkbox"/> Record <input type="checkbox"/> Other _____	
BENEFICIARY'S SIGNATURE	DATE
ADDRESS (No., Street, City, State, ZIP Code)	TELEPHONE NO.
COUNSELOR'S SIGNATURE	DATE
ADDRESS (No., Street, City, State, ZIP Code)	TELEPHONE NO.
