

RELEASE OF INFORMATION FOR PROCESSING BENEFITS

I hereby authorize Lake-Cook Behavioral Health Resources to release any of the following requested information for the purpose of obtaining reimbursement/payment for treatment services provided directly to me or my dependents. Information may include:

- 1. Admitting diagnosis
- 2. Health screening
- 3. Discharge summary
- 4. Final diagnosis
- 5. Designated clinical records, e.g., treatment plans, progress notes, laboratory results, etc.

Information may be released to any or all of the following as needed:

- 1. Any third-party payor having responsibility for payment of charges for treatment
- 2. Review agents/auditors
- 3. Managed care/utilization review agents

This consent is valid until such time that all claims have been settled to the satisfaction of Lake-Cook Behavioral Health Resources or up to one year from the date of discharge from Lake-Cook Behavioral health Resources, whichever is longer.

I understand that in some cases, I and/or my dependents may be receiving services for which I am not the insured or for which there is more than one insured. In this case, I authorize Lake-Cook Behavioral Health Resources to contact the actual or additional insured (e.g., my spouse) and to share information necessary to obtain reimbursement for services.

I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. I further understand that I can invalidate this consent any time before the expiration date so long as I submit revocation in writing to the address listed below. Finally, the agency reviewing the clinical information and/or records will be advised not to disclose my records to any other agency/person without my written informed consent.

I understand that I am ultimately responsible for any and all charges not paid for by my medical insurance, and that if I refuse to sign this Release of Information, I will likely have to pay for any and all charges incurred.

I certify that I am the client and that I have received a copy of this form. If I am not the client, I certify that I am adult authorized as the client's general agent to execute the above and accept its terms.

Client's name: _____
(print)

Signature: _____ Date: _____
(client or authorized representative)

Witness: _____ Date: _____

If the client did not sign this form, what is the relationship of the signer to the client? _____

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ASSIGNMENT OF BENEFITS: In consideration of services to be provided to me or to my dependent, I hereby assign, transfer and set over to Lake-Cook Behavioral Health Resources, all of my rights, title and interest to reimbursement benefits under my insurance policy(ies), including any and all major medical benefits. I understand I am financially responsible to Lake-Cook Behavioral Health Resources for charges not covered by this assignment.

Signature: _____ Date: _____
(person insured)

White copy: chart Yellow copy: office Pink copy: client