LAKE COOK
BEHAVIORAL HEALTH

RELEASE OF INFORMATION

FOR PROCESSING BENEFITS

I hereby authorize Lake Cook Behavioral Health 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 notes, etc.

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

1. Any third-party payer 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 satisfactions of Lake Cook Behavioral Health or up to one year from the date of discharge from Lake Cook Behavioral Health, 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 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 agent to execute the above and accept its terms.

Client's name:(printed)_____

Signature:(client or authorized representative)_____Date_____

Witness: _____

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, all of my rights, title and interest to reimbursement benefits under my insurance policy(ies), including any and all major medical benefits. I understand that I am financially responsible to Lake Cook Behavioral Health for charges not covered by this assignment.

Signature:_____Date_____

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