rosecrance

ROSECRANCE AND AFFILIATES
Financial Release of Information

Client Name: _____ Client ID: _____ Client DOB:_____

Release of Information
This release of information is to secure payment for services provided by Rosecrance Health Network and Affiliates ("Rosecrance") and applies to the following information: *your presence in treatment; your demographic and medical information; treatment information and records including assessment, diagnosis, treatment plan, dates of service, type of service and level of care received; financial information; and any other information that is necessary to obtain authorization for services, to determine eligibility, to coordinate benefits, to submit health care claims, and to obtain reimbursement from a third-party payer or funding source.*

Indicate which of the following entities, payers, or funding sources are allowed to exchange information with Rosecrance:

X	Name	Description
		Parent/Guardian/Spouse
		Parent/Guardian
		Third Party Payer
		Third Party Payer
	Illinois Department of Human Services ("DHS"), Healthcare & Family Services ("HFS") ("Medicaid")	**Third Party Payer**
	Centers for Medicare & Medicaid Services ("Medicare")	**Third Party Payer**

Insurance Plan Information
I hereby authorize my plan administrator, the plan fiduciary, the insurer, and my attorney to release to Rosecrance any and all Plan documents, summary plan benefit description, insurance policy, medical necessity criteria, reasons for denial, and settlement information upon written request from Rosecrance or its attorneys in order to claim benefits or to pursue any internal or external appeal or legal or administrative remedies.

Parent Companies and Subsidiaries
I authorize Rosecrance to exchange information with the entities listed above and any wholly owned subsidiaries owned by that entity who are involved in processing claims and handling my insurance benefits.

Purpose and Condition
The purpose of this disclosure of information is for Rosecrance to obtain authorization and payment for treatment services provided to the client. I understand that treatment is being provided to the client in reliance on obtaining payment for services rendered.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the Medical Records Department at Rosecrance. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration and Redisclosure
Unless sooner revoked, this consent expires one year after the last date on which services were provided, or until all claims relating to my treatment are paid in full, whichever is later. State and Federal law prohibit the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et seq.).

_____ _____
Signature of Client Date

(Clients ages 12-17 years old are requested to sign and date with co-signature of parent/legal guardian) If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ _____
Name of Parent, Guardian or Personal Representative (Print) Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)._____

_____ _____
Printed Name of Staff Signature of Staff Witness Attesting to Identity Date

THIS FORM MEETS ALL REQUIREMENTS OF 42 CFR PART 2, THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT, AND 45 CFR PARTS 160 & 164 (HIPAA)