Midwest Behavioral Care, Ltd.
Administrative Office 3821 Little York Road, Dayton, OH 45414

AUTHORIZATION TO RELEASE PHI FROM MBC FOR INSURANCE BILLING

Client Name _____ S.S. # _____ Birth Date _____

__x__ Assessment and Diagnostic Impression	__x__ Treatment Plan and/or Outcome
__x__ Medications Used and Response to the Medication	__x__ Treatment Plan and/or Outcome
__x__ Assessment of Client's Substance Use/Abuse and Stage of Recovery	__x__ Client Identifying Information
__x__ Recommendations for Follow-Up	__x__ Indicators of Progress
__x__ Psychosocial History	__x__ Psychological Evaluation
__x__ Admission Summary	__x__ Discharge Summary

_____Other_____

This information should only be released to the Following Insurers and/or their Designees:

_____

_____

I am permitting Midwest to release this information for the purpose of utilizing my medical benefits to help with payment on my account for professional services rendered by the professional staff of Midwest Behavioral Care, Ltd.

This authorization shall remain in effect until all claims have been settled.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the above office address. However, your revocation will not be effective to the extent that Midwest has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Also, revocation of this consent will render the signee and/or guardians responsible for payment in full on this account.

I understand that Midwest generally may not conditional psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I release Midwest Behavioral Care, Ltd. and its personnel from any legal liability resulting from the release of this information wit the understanding that Midwest Behavioral Care, Ltd. personnel will exercise reasonable professional safeguards regarding this information.

I have read and understand this document.

Signed this _____ day of _____. 20_____.

Signature of Client(s) _____

Signature of Parent or Guardian, if applicable_____.

Signature of Witness_____

A TRUE PHOTOCOPY HEREOF MAY BE CONSIDERED AS AN ORIGINAL.