Consent to Release Confidential Information – Insurance Company/Funding Source

Patient Name_____ DOB_____ Client ID_____

I authorize Gateway Rehabilitation Center to release confidential information as specified below to my insurance company for the purpose of Health Insurance/Billing.

Insurance Company(s)_____

You may revoke this consent verbally or in writing at any time except to the extent that action has been taken in reliance upon it.

The information that will be disclosed to my insurance company/funding source includes the following:

- Whether the client is or is not in treatment
- Prognosis of the client
- Nature of the project
- Brief description of the progress of the client
- A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse

This information that will be disclosed to my insurance company/funding source includes information from my admission date through discharge date.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I may revoke this consent verbally or in writing at any time except to the extent that information has been released prior to the date of revocation by contacting the Medical Records Department.

Unless I have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information permitted by this authorization in any manner that we deem to be appropriate and permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

In any event, this consent shall expire in one year from the date of signature.

Federal law prohibits 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.

_____ _____
Patient Signature Date

_____ _____
Parent/Responsible Party Signature (If required) Date

_____ _____
Witness Signature Date

Copy Accepted Copy Refused