Patient Name (print):_____
Birthdate: _____

AUTHORIZATION TO RELEASE INFORMATION FOR PAYMENT AND REIMBURSEMENT PURPOSES

I, _____, (print name) authorize Hazelden Betty Ford Foundation and its affiliated entities and Recovery Partners, PC ("Hazelden") to release information and medical records regarding my medical health, mental health and chemical dependency, as specifically requested, with respect to my treatment to my insurance companies, its affiliated entities, contractors, subcontractors and any and all parties involved in the review, processing and payment of claims related to services provided by Hazelden. (Optional) _____ I do not wish to have my HIV/AIDS testing results included.

I understand the purpose of this insurance authorization is to file, process and support the claim(s), communicate information needed to substantiate the claim and participate in the review process to determine medical necessity for my level of care and continued stay and for health care operations purposes.

I hereby authorize payment directly to Hazelden Betty Ford of the policy benefits otherwise payable to me, but not to exceed the provider's regular charges.

In the event that the insurance company paying for my care determines that my stay at Hazelden Betty Ford is no longer medically necessary, I may choose to continue receiving treatment at Hazelden Betty Ford, provided that prior to receiving such continued treatment I or my guarantor may be required to sign a waiver acknowledging financial responsibility for such non-covered services.

I understand that the insurance information that has been given to me is believed to be accurate but is not a guarantee. Final determination of my eligibility and benefits are controlled by the terms of my insurance contract. Under Managed Care Contracts, if it is determined that my stay is no longer medically necessary, I recognize that benefits can be reduced or denied in accordance with the conditions of my contract. I understand these statements to mean that I could have additional financial responsibilities that the staff at Hazelden Betty Ford are not aware of at this time.

In the event an advance deposit has been made by me or on my behalf, any unused portion of that deposit will be refunded to the payor in the same manner as paid (e.g. credit card charges will be refunded to credit card or if paid in cash will receive a check), following my discharge. Should an insurance company pay for my care, a refund will be made to the appropriate payor upon Hazelden Betty Ford's receipt of payment in full from the insurance company. However, if I have received patient aid, that aid will be repaid to Hazelden Betty Ford before a refund is given.

I understand that Hazelden Betty Ford may find it necessary to communicate with persons regarding my funding arrangements, billing, collection of my account and current mailing address. I authorize Hazelden Betty Ford and its representatives to have written and/or verbal contact with the following individuals:

Additional Authorized Payor/Guarantor:_____

Financial Institution: Visa, MasterCard, Discover, American Express (only in the event there is an issue/question with your credit card payment to Hazelden).

Others authorized to discuss with:

_____ _____

_____ _____

_____ _____

I understand that I can revoke this authorization at any time except that Hazelden Betty Ford continues to be authorized to make disclosures necessary to be paid for services rendered to me on or prior to the date of revocation. If I revoke this authorization I will be responsible for payment in full of all my treatment costs to the extent they are not otherwise paid on my behalf. If not previously revoked, this release will remain in effect for the period reasonably needed to complete the request.

Date_____ _____ Date_____ _____

Patient Signature Parent/Guardian Signature