



Patient Name(print): _____

Birthdate: _____

AUTHORIZATION TO RELEASE INFORMATION FOR PAYMENT AND REIMBURSEMENT PURPOSES

I, _____, (print name) authorize Hazelden Foundation (“Hazelden”) to release information and medical records regarding my medical health, mental health and chemical dependency, as specifically requested, with respect to my treatment, ___ including ___ not including (or not applicable) HIV/AIDS information to:

Name of Insurance Company

To the extent that my treatment is subject to concurrent review, I authorize Hazelden to release information and medical records regarding my medical health, mental health and chemical dependency, as specifically requested, with respect to my treatment, ___ including ___ not including (or not applicable) HIV/AIDS information to:

Name of Review Agency/Managed Care Company

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.

I hereby authorize payment directly to Hazelden 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 is no longer medically necessary, I may choose to continue receiving treatment at Hazelden, 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 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 following my discharge. Should an insurance company pay for my care, a refund will be made to the appropriate payor upon Hazelden’s receipt of payment in full from the insurance company. However, if I have received patient aid, that aid will be repaid to Hazelden before a refund is given.

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

Guarantor: _____
Father: _____
Mother: _____
Spouse: _____

Financial Institution : _____
Employer: _____
Administrative Assistant: _____
Other: _____

Date Patient Signature

Date Parent/Guardian Signature

Please send form to: Hazelden Foundation, PO Box 11 RW 18, Center City, MN 55012-0011