

**Authorization for Assignment of Benefits**

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| Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

The undersigned hereby authorizes and requests **Heartland Regional Alcohol/Drug Assessment Center, P.O. Box 1063, Shawnee, KS, Phone: 913-789-0951, Fax: 913-789-0954.**

[x] To Release to [x]  Obtain from

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| x The Designee of Beacon Health Options / Value Options of Kansas  |
| x The Designee of Aetna Better Health of Kansasx The Designee of Sunflower State Health Planx The Designee of United Healthcare Community Plan of Kansas |
| \_\_ The Designee of : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  (Other Third Party Payer) |

The following information:

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| [x] Assessment Results | [x]  Transitional Plan |
| [x] Kansas Client Placement Criteria Results | [x]  Discharge Information & Summary |
| [x]  Consultations | [x]  Laboratory Reports |
| [x]  Progress Notes | [x]  Complete Records |
| [x]  Permission to file Appeal &/or Grievance if services are denied | [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

The above information is released for the purpose of processing payment of medical services thru insurance carriers, prepaid medical plans, or governmental agencies. I understand that my records (including psychiatric, alcohol abuse or drug abuse information) may be protected by Federal Regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires one year after the date entered below (date of signature).

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Executed this (day) \_\_\_\_\_\_of (month) \_\_\_\_\_\_\_\_\_\_\_\_, (year) 20\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Client Signature Date |
| Signature of Parent, Guardian or Authorized Representative Date Nature of Relationship |
| Signature of Witness Date  |

Prohibition on re-disclosure: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2.) The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient