Intercommunity Action, Inc.
Release of Info to Third Party

Client: Test, Test **DOB:** 10/06/1987 **Gender:**Female **ID#** 00000001 **Intake:** 05/04/2015 05:00am

Test

Client:

Event:

Actual Date:

Location:

Staff:

Attached Document/Signature: No document attached

Release Information:

Authorization to Release Information to Third Party Payors

I hereby authorize Intercommunity Action, Inc. to release to my insurance company(s), making payment on my behalf, copies of psychiatric and/or medical information limited to dates of service, mode of therapy, clinician and/or doctor signature, diagnosis fees, and such additional information as my insurance company(s) may request from the medical record pertaining to my treatment of the Admission date listed below through the date of discharge for this special admission listed below. The information which may be released shall be a part of the medical record deemed necessary by my insurance(s) for the purpose of verifying my claim. If I am receiving drug and alcohol treatment, only the following information may be released: (1) whether or not I am in treatment, (2) my prognosis, (3) the nature of the project, (4) a brief description of my progress, and (5) a brief statement as to whether I have relapsed and the frequency of such relapse.

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Admission Date

Discharge Date

I understand that my authorization shall remain valid from the date of my signature, documented here, and for six (6) months following the date of my termination.

Date of Signature

I have been informed that I may revoke this authorization by written or oral communication to the Medical Record Administrator of INTERCOMMUNITY ACTION, INC. I have also been informed of my right to inspect certain information to be released. The information hereby released is released at my request and for my benefit. I will indemnify and hold INTERCOMMUNITY ACTION, INC. harmless with respect to any claims asserted because of this release.

I certify this form has been fully explained to me and that I understand its contents. I permit a copy of this authorization to be used in lieu of the original.

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Client Signature (14 or older for MH)/Date:

Signature Authorized Person in Lieu of Client/Date:

Relationship to Client:

Verbal Consent

Verbal Consent Release Information:

Signature of Witness/Date:

Title of Relationship:

Signature of Witness/Date:

Title of Relationship:

Entered With:

Service Related Encounter Information

Exempt from Billing:

Activity Type:

Client Involved:

Program Providing Service:

Facility Providing Service:

Encounter With:

Service Authorization:

Tasks/Schedules

Next Event Due:

Next Scheduled Event