Ascension Behavioral Healthcare, P.A.

CONSENT FOR RELEASE OF PATIENT INFORMATION FOR REIMBURSEMENT AND CONTINUITY OF CARE

I authorize Ascension Behavioral Healthcare, P.A. to release such social, demographic and diagnostic and therapeutic (including any treatment or test results for alcohol and/or drug abuse, or reportable communicable disease, including Acquired Immune Deficiency Syndrome or Human Immune-deficiency Virus Infection) for this period of inpatient hospitalization or outpatient treatment for one year from the date of this authorization to the following:

- My insurance carriers(s), the Social Security Administration, its intermediaries or carriers, or any party that is or may be liable for all or part of the hospital and and/or physician charges as may be necessary for the purpose of enabling the insurance carrier(s) or Social Security Administration to determine the benefits available to me for the services rendered by Ascension Behavioral Healthcare, P.A.
- Individuals, agencies, or facilities working with Ascension Behavioral Healthcare, P.A. staff as may be necessary to assist me with Discharge planning.
- The Social Security Administration if applicable, for use in determining my eligibility for disability benefits.
- I further authorize Ascension Behavioral Healthcare, P.A. to disclose patient-identifiable information about me for the purposes of seeking reimbursement assistance or for enrolling me in pharmaceutical patient assistance programs that may provide certain products free of charge or at a reduced rate. I understand that, in order to obtain reimbursement assistance or to determine my eligibility to participate in patient assistance programs, certain information about me, including, without limitation, the type and date of my medical diagnosis and treatment, my family income and my health insurance will need to be provided by Ascension Behavioral Healthcare, P.A. to the pharmaceutical manufacturer(s) or their agent(s) for the product(s) prescribed to treat my condition. I understand this information will not be used for any other purposes than that as described above.

I further authorize the use of photographic reproduction of this authorization in place of the original.

I understand that I may withdraw this authorization at any time but must do so in writing.

_____ _____

Patient or Authorized Person's Signature Relationship to Patient

_____

If patient is unable to sign, indicate the reason

_____ _____

Signature of Witness Date of Signatures

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