North Central Health Care

Person centered. Outcome focused.

FINANCIAL RELEASE OF INFORMATION

Name: _____ DOB:_____ MRN:_____

Consent Date: _____ Expiration Date: _____

I request and authorize:
NORTH CENTRAL HEALTH CARE FACILITIES, 2400 Marshall St, Wausau, WI 54403 to release information (including photocopies) from my records necessary to recertify/authorize services and process my claim for insurance benefits, Medicare (and its agents), any commercial insurances, or Medicaid payment, for services provided by North Central Health Care. This includes mental health, alcohol/drug, developmental or other medical diagnoses, discharge summaries and clinical notes to include physician orders, treatment plans (where required) and test results (include HIV). The purpose of this authorization is to enable the recipient to precertify/authorize and process my claim. I understand I have the right to inspect and receive a copy of this form and the material to be disclosed as required under State Statute HFS 92.05 and 92.06. This consent is given voluntarily, and I understand that treatment services are not contingent upon my decision concerning this release of information.

I may revoke this consent at any time except to the extent that action has been taken in reliance on it (45 CFR 164.508(c)(2)(i)). This consent (unless expressly revoked earlier) is valid for ***(select only one):***

- Duration of the NH Admission
- One (1) year from date of signature for Outpatient Services
- Duration of Hospital Service

The confidentiality of the information from the records disclosed is protected by Federal Regulations 42 CFR (Part 2) and 45 CFR 164.508 and/or Section 51.30, 146.81 and 252.15 Wisconsin Statutes which prohibit the possessor from making any further disclosure of it without the specific written consent of the person to whom it pertains.

I also authorize and request payment directly to North Central Health Care of all benefits otherwise payable to me for services provided by North Central Health Care, not exceeding it regular charges. I understand that, as the patient, I am financially responsible for all charges regardless of whether paid by the insurer. This assignment cannot be revoked without the written consent of North Central Health Care.

Also, if needed to initiate or facilitate enrollment/recertification in the Medical Assistance Program, I authorize North Central Health Care to contact and share information with the County Department of Social Services. Medicare agents include Fiscal Intermediaries (FI), Carriers (A/B MAC), Durable Medical Equipment Contractors (DME MAC), Medicare Part C HMOs, and/or Medicare Part D private insurance Contractors.

By signing this, I hereby authorize North Central Health Care to bill all my insurance companies for the services that I am receiving.

_____ _____
Signature – Patient/Client *Date/Time Signed*

_____ _____ _____
Signature – Parent/Guardian/Other *Relationship* *Date/Time Signed*

_____ _____ _____
Signature – Policyholder *Relationship* *Date/Time Signed*