Cottonwood Clinical Services, Inc.

INSURANCE RELEASE OF INFORMATION AUTHORIZATION

Insured Details:

Insurance Company Name: _____

Insured ID#: _____ Group Policy #: _____

Insured's Employer Name: _____

Insured Name: _____ Gender: M F

Insured Date of Birth: ____/____/_____ Insured Phone Number: _____

Insured Address: _____

_____

_____

Is the Insured Responsible for Patient? Y N

Patient Details:

Patient Name: _____ Gender: M F

Patient Date of Birth: ____/____/_____ Patient Member ID#: _____

Patient Address: _____

_____

_____

Relationship to Insured: (Natural Child, Foster Child, Niece, Etc.) _____

Financial Information (Medicaid and Saluds Only)

Annual Household Income _____ No. Of Dependents _____

Release from Liability

I understand that this information is or may be protected by federal regulations and hereby release the releaser/receiver named above from any liability associated with the release of such information. I also understand that I may revoke this consent at any time and that this authorization automatically expires as noted below. Drug/alcohol abuse information is protected under Federal Law CFR 42, Pat 2, and may not be released except by written authorization. I understand that my mental health / substance abuse information may be submitted to my above listed insurance company, and/or third party billing services such as clearinghouses, for billing purposes only.

This release expires one year from the date of authorization.

Patient Signature: _____ Date: _____

Parent/Guardian/Insured (If Required): _____ Date: _____