**Family Solutions of Ohio**

**DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF SERVICES**

**VALID UNTIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EFFECTIVE DATE IF REVOKED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **NOTICE:**  I understand that under HIPAA law, 45 CFR Part 164.501, Family Solutions of Ohio may exchange necessary protected health information with Medicaid or other health insurance company that I am covered, to receive payment for services rendered to me. Under Mental Health Services, FSO may disclose information necessary to be reimbursed even if I do not authorize disclosure of my protected health information. **I understand however that to seek payment for alcohol and drug services I received, I must authorize disclosure of protected health information.** |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Family Solutions of Ohio to disclose protected health information to seek reimbursement for services including services related to drug and alcohol.

**All services delivered (Mental Health and Alcohol Program)**

* To verify my eligibility for Medicaid or other third party reimbursement sources.
* To submit the necessary protected health information to receive payment for services I received.
* To disclose all necessary information from my record for payment, utilization management, and review/audit conducted by the insurer or insurer representative as authorized by law.
* I understand that additional information may be requested from my record by the insurance company or insurer representative from my records after payment has been made for purposes as defined by law.
* I am responsible to notify Family Solutions in case of change of my health insurance coverage.
* I understand that ultimately, I am responsible for all payment relating to all charges relating to treatment and services that I have received that is not covered by Medicaid or other insurers. If my account is not paid within 90 days or proper financial payment plan has been made, FSO may turn-over my account to a collection agency.
* I understand that I may revoke this authorization at any time except to the extent action has been taken in reliance to it by FSO. If not revoked, this authorization will expire in one year or until the satisfaction of claims for services provided during the year.
* By signing below, I agree, understand and accept the above terms and conditions.

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| Client Signature (including minor for AoD Services) | Date |
| Signature of Parent/Legal Guardian | Date |
| Signature of Witness | Date |

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**REVOCATION:**  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ revoke the above authorization effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_