RIMROCK
LEADING ADDICTION TREATMENT

Financial Authorization for Use or Disclosure of Protected Health Information

Name: _____
Date of Birth: _____
Age: _____
Gender: _____

I, hereby authorize Rimrock, 1231 North 29th Street, Billings, MT 59101, and the following named agencies and/or persons, to release use, disclose, and exchange with each other information as indicated below:

Name: Medicaid

(Insurance Company and its affiliates and contractees, including its utilization review or pricing companies)

Address: P O Box 8000
City: Helena State: MT Zip: 59604-8000
Phone: (800)624-3958 Fax: Email:

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____Ext: _____
Fax: _____ Email: _____

The type and amount of information to be disclosed is as follows:
☑ Minimum necessary medical, clinical, and financial information to facilitate payment
☐ Other (specify) _____

For Purpose of:
☑ Verification, authorization, collection, and appeal of insurance benefits
☑ Utilization Review ☑ Financial Benefits/Payment Services
☐ Other (specify) _____

I understand that my drug and or alcohol treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and my health information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Part 160 and 164. My information cannot be disclosed without my written authorization unless otherwise provided for by the regulations. I understand that I may revoke this authorization at any time by notifying Rimrock, except to the extent that action has been taken in reliance on it.

This authorization will expire on the following event: **Payment in full for services**

I understand that I might be denied services if I refuse to consent to disclosure for purposes of treatment, payment or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have read and understand this authorization and have received a copy of it.

Method of Disclosure: ☑ Phone ☑ Mail ☑ Email ☑ Fax ☑ In Person ☐ Other: _____

_____ Client Signature

_____ Parent/Guardian

_____ Witness

_____ Personal Representative

Describe authority to sign on behalf of client

_____

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

Section 2.32. Prohibition on Re-disclosure of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This Information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this Information unless further disclosure is expressly permitted by the written consent of the person to whom It pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or persecute any alcohol or drug abuse patient.

SUBMIT