Insurance Information

Primary Insurance Carrier

Name of Primary Insurer (Company Name)

Address of Policy Holder | City | State | Zip

Policy Number | Group Number

Policyholder's Last Name | First Name | Middle Initial | Date of Birth

Policyholder's Employer | Social Security Number

Relationship to Policyholder: ☐Self ☐Spouse ☐Child ☐Other

Secondary Insurance Carrier

Name of Secondary Insurer (Company Name) | Office Co-Pay Amount

Address | City | State | Zip

Policy Number | Group Number

Policyholder's Last Name | First Name | Middle Initial | Date of Birth

Policyholder's Employer | Social Security Number

Relationship to Policyholder: ☐Self ☐Spouse ☐Child ☐Other

Authorization

I authorize Catholic Charities to release any Protected Health Information (PHI) necessary to process insurance claims for services received at Catholic Charities. Unless explicitly authorized by me, the Psychotherapy Notes will not be disclosed to my insurance carrier or managed care company. I further authorize payment of benefits to which I am entitled form any insurance company to Catholic Charities for services described on any insurance claim filed on my behalf. I understand I am financially responsible for any amount not covered by my insurance contract.

Printed Name

Signature | Date

If client is under 18 years of age:

Parent/Legal Guardian's Printed Name

Address | City | State | Zip Code | ( ) Phone

Parent/Legal Guardian's Signature | Date

Catholic Charities Counseling Services
Authorization to Release PHI to PCP

First Name ______ Middle Initial ______ Last Name ______

Address ______ City ______ State ______ Zip ______

Date of Birth ______ Medicaid Number (if applicable) ______

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share Protected Health Information (PHI) with your Primary Care Physician (PCP). This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

I, ______________________, hereby authorize ______________________ from Catholic Charities Counseling Services to release Protected Health Information related to my evaluation and treatment to:

Primary Care Physician ______ Address ______ City ______ State ______ Zip Code ______ Phone ( )

Please check one of the following:

- ☐ Permission to release any applicable mental health/substance abuse information to my Primary Care Physician.
- ☐ I DO NOT give authorization to release any information to my Primary Care Physician.

Information to be completed by Behavioral Health Provider

I saw the above named client on __________ for ______________________
Reason/Diagnosis

If you have any questions or would like to discuss this case in greater detail, please call Catholic Charities at

______________________.

Provider's Signature ______ Provider's Printed Name/Licensure ______

CLIENT RIGHTS

- You can end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
- For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to this request to use or disclose your information.

CLIENT AUTHORIZATION

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified below. I have read and understand the above information and give my authorization.

This authorization expires on ______________________.

Signature ______ Date ______

Signature of Client's Authorized Representative ______ Relationship to Patient ______ Date ______

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited 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 prosecute any alcohol or drug abuse patient.