Ideal Option

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

[THIS RELEASE ALLOWS IDEAL OPTION TO BILL SERVICES TO YOUR INSURANCE]

I, _____ (DOB: _____) authorize Ideal Option, PLLC to communicate with and disclose to one another the following information:

Name of business/person:	Any Third-Party Payor (Commercial Insurance Company/Medicaid/Medicare/etc.) related to my care at Ideal Option, PLLC

The purpose of this disclosure is: **Billing and Collection**

Type of Information to be Disclosed:

_____ Complete Patient Record for Billing and Collection
(including progress reports, chart notes, UA results,
lab tests, TB tests, treatment plan, demographics,
verification of funding source(s), and billing documentation)

_____ Other and/or limited information: _____

I authorize Ideal Option, PLLC to disclose to any third-party payor all necessary information and relevant portions of my patient record for the purpose of receiving payment for services rendered.

I authorize Ideal Option, PLLC to disclose to any third-party payor all necessary identifying demographic information for the purpose of protecting against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats against third parties.

I understand that my alcohol/drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it (including the provision of treatment services in reliance on a valid consent to disclose information to a third party payer), and that in any event this consent expires 365 days after my deactivation from Ideal Option as a patient or as otherwise follows:

_____

(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will and that by signing I have reviewed and understand the terms of this consent. I have been provided a copy of this document.

Dated: _____ Signature of Patient: _____