Healthy Minds Behavioral Health Clinic
9492 W Fairview Ave, Boise, ID 83704
Fax # 2082133659
Phone #2082847100
Email info@healthyminds.clinic

Release of information

Authorized for disclosure

First & Last Name:

Date of Birth:

Patients Home address

Patients Phone No.

Providers office requesting or needing information:

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I authorize the following person or business to release or disclose confidential information about

me: Primary Doctor Name or Clinic Name

Purpose of Disclosure: Codination of care

Type of information to be disclosed ____Psychiatric _____Drug/Alcohol_____LABS

Description of information requested:

This authorization is good until __X__1 yr. I understand that I am under no obligation to sign this form and the person and/or organization listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits or my decision to sign this authorization.

I understand that if the person and/or organization listed above are not healthcare providers, health plans, or healthcare clearinghouses that must follow the federal privacy standards that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information could be re-disclosed without my authorization. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization. I understand that I have a right to receive a copy of this authorization.

Copy requested and received _____Yes No _____ I do not want a copy of this. I release the person/agency disclosing this information from any liability arising from the release of information to the agency or person designated above. Federal rules prohibit further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

Patient or Guardian signature _____ **Date** _____

Witness signature _____ **Date** _____

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Consent to Treatment / Telehealth/ Financial Responsibility / Authorization to Release Medical Information / Assignment of Benefits

I _____ consent to telehealth/ in office treatment to be rendered to (Patient or Responsible Party- please print) me, my dependent, or other person designated below, and, in so doing, agree to be responsible for the payment of professional fees. Such fees or supplemental charges, may include, but are not limited to patient copays, deductibles, non-insured services (ie., prescription renewals outside your appointment time, pharmacy authorizations, telephone/email communications, document preparation, hospital admission coordination), or services deemed by my insurance company or its agents as medically unnecessary. If my insurance does not cover the charges, then am responsible for payment and the credit card on file can be used to make the whole payment. A fee of $25.00 is charged for missed appointments, unless canceled 24 hours in advance. The office does not file out of network claims but will provide a statement for you to file. Full payment for those covered by a non-network plan is due at the time of service.

I authorize health minds behavioral health, or those acting in its behalf, to provide information regarding my medical, psychiatric, or substance abuse treatment to my insurance company or its agents for the purpose of determining benefit eligibility, for certification of care, or for claims processing purposes. This authorization is valid until revoked in writing by me or by my legal guardian. By signing this document, I represent Healthy Minds Behavioral Health clinic. and its employees that I have in force, and am entitled to, the benefits of any applicable health plan which I have presented.

I assign any insurance benefits to Healthy Mind Behavioral Health Clinic

Patients signature _____ **Date** _____

Witness signature _____ **Date** _____