AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
FOR INSURANCE COMPANY

Client Name: _____ Date of Birth: _____

Client Address: _____ City/State/Zip: _____

Phone: ( ) -

The undersigned hereby authorizes and requests the release of confidential health information for review, examination and/or photocopies between **Porter-Starke Services, Inc.**, 601 Wall St., Valparaiso, IN 46383 and the listed **insurance company.**

Please Print Clearly

Insurance Company Name: _____

Access to this information is limited as designated below.

RELEASE IS VALID FROM THE DATE SIGNED UNTIL THE ACCOUNT IS SATISFIED WITH INSURANCE COMPANY

Portions Of The Medical Record to be Released to Insurance Company Include:
Bill codes, service dates, provider(s), and diagnosis
Notes and/or Treatment Plan and demographic information may be released if requested by the insurance company.

Purpose of Release:
To bill provided services to the insurance company and to communicate with the Insurance Company listed, the MCO (Managed Care Organization) or Carve-out plan as needed for authorizations, payment and continuity of care.

I fully understand that my medical record contains confidential physical, mental health, substance abuse, and/or HIV/AIDS information compiled in the course of my treatment. The medical records and/or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, as required by law. I understand that I cannot be required to sign this authorization as a condition for having treatment provided or obtaining payment for the same.

Date, event or condition this authorization expires 60 days after services have been terminated or when all financial responsibilities have been satisfied with the insurance company. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written revocation request to the Health Information Department.

This information may be disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit 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.

Patient Signature:_____ Date: _____

Relationship to Patient: _____ Request Received by:_____
(if signed by responsible party)

PORTER-STARKE SERVICES, INC

CLIENT NAME: _____

CLIENT NUMBER: _____

Once completed, submit this authorization form by:

- **Mail** to Porter-Starke Services/HIM Dept, 601 Wall St, Valparaiso, IN 46383, or
- **Fax** to 219.462.3975, or
- **Email** using a secure platform to HIM@porterstarke.org