The Emily Program

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FOR PAYMENT AND REIMBURSEMENT PURPOSES

Client Information *Please print legibly.*	Name*: _____ Date of Birth*:_____ Other Names Used:_____ Phone Number:_____ *Parent/Guardian/Legal Representative Name (where applicable):* _____
Insurance Company Information/TPA *With **Whom** may The Emily Program and/or its management company, TEP Management Company (collectively, "The Emily Program") share your information?*	_____ Name of Insurance Company/Third Party Administrator* _____ _____ Phone Number Fax Number _____ Address (street, city, state, zip code) **Required Field*
Communication ***How** will The Emily Program share your information?*	I authorize The Emily Program to exchange the information indicated below by verbal communication, or by sending and requesting paper copies via US mail or fax.
Information to be Released ***What** is to be released?*	I authorize The Emily Program to release ALL information pertaining my treatment, including, but not limited to: Intake Evaluations/Diagnostic Assessment Individual Therapy Notes/Progress Notes Nutritional, Medical, and Psychiatric Documentation Treatment Plans/Discharge Summaries Treatment Plans/Discharge Summaries Substance Use Disorder Records Administrative Records (e.g. appointment listings, billing) HIV/AIDS Records
Purpose of the Release of Information ***Why** is the release needed?*	I understand the purpose of this release is to file, process, and support insurance claim(s), obtain authorization, communicate information needed to substantiate the claim, and participate in the review process to determine medical necessity for my level of care and continued stay.

Statement of Authorization:

I understand that:

- I may revoke this consent at any time, except to the extent that The Emily Program has already acted in reliance on it, by providing oral or written notice to The Emily Program at the address noted in the Notice of Privacy Practices. If I revoke this authorization, I will be responsible for payment in full of all my treatment costs to the extent they are not otherwise paid on my behalf. **This consent automatically expires three (3) years after my last date of service at The Emily Program.**
- I have been informed what information will be released, its purpose and who will receive the information, and I may inspect or copy the protected health information to be used or disclosed under this authorization per applicable state and federal laws.
- I understand that any substance use disorder treatment and diagnosis records are protected under federal regulation 42 CFR Part 2 and disclosure is allowed only with this specific authorization, except in limited circumstances as stated in The Emily Program's Notice of Privacy Practices and Informed Consent.
- Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from substance use disorder records. However, HIPAA requires The Emily Program to notify me that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA.
- I understand that I may refuse to sign this authorization. The Emily Program will not condition treatment based on whether I sign this authorization. I understand if I refuse to sign this authorization, I am electing to self-pay for services at The Emily Program as specified in the Financial Policy Agreement.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THIS AUTHORIZATION FORM AND AUTHORIZE THE EMILY PROGRAM TO RELEASE THE ABOVE SPECIFIED INFORMATION TO THE PARTY IDENTIFIED ABOVE FOR THE REASON IDENTIFIED ABOVE.

_____

Client Signature* Parent/Guardian/Representative Signature **Date**

Age of Consent for **mental health records by state: Minnesota: 18; 16 for residential. Washington: 13, Ohio: 18; 14 for outpatient, Pennsylvania: 14.*
Age of consent for **substance abuse records by state: Minnesota: any age; Washington: 12 for outpatient, 18 for residential; Ohio: 18; Pennsylvania: any age.*

Legal Representative *(where applicable):* I am legally authorized to represent the client listed above and I understand that I may be asked to provide documentation to demonstrate this legal authority.

_____

Legal Guardian/Representative Signature Relationship to Client/Legal Authority Date

Financial ROI FAQ

What is a Financial Release of Information Form (ROI) and what is it for?

A Financial Release of Information Form (ROI) documents your consent for The Emily Program to share information regarding your treatment to your insurance provider. It is necessary for The Emily Program to share this information so that your insurance provider can file, process, and support insurance claims.

Why is a Financial ROI needed?

To comply with federal health care laws and to ensure your continued right to privacy, The Emily Program must obtain your consent in writing before communicating with your insurance provider about you or the services you are receiving at The Emily Program.

For how long is this ROI valid?

The Financial ROI is valid for three (3) years from your last date of service at The Emily Program, unless you revoke the ROI prior to that date.

What if I/we decide not to fill out an ROI?

If you decline to fill out a ROI for your insurer, The Emily Program will not be able to bill the insurer for your services and you will be financially responsible for all services and charges incurred while obtaining eating disorder treatment at The Emily Program. Declining to complete a Financial ROI means that you are electing to self-pay for services at The Emily Program as specified in the Financial Policy Agreement.

How can I revoke my consent?

Financial ROI's can be revoked before their expiration date. To do this, please send a signed and dated letter stating which authorization/with whom you would like to revoke your Financial ROI. Please send this letter to us at: The Emily Program, 1295 Bandana Blvd N, #210, St. Paul, MN 55108. Letters that are received will be kept in your chart as record of the revoked release.