



AUTHORIZATION TO PROCESS INSURANCE

I hereby authorize Lake Cook Behavioral Health to release clinical information for the purpose of processing insurance benefits and receive payment for treatment services. This consent is valid until such time that all claims have been settled to the satisfaction of Lake Cook Behavioral Health or up to one year from the date of discharge, whichever is longer.

Information may be released to any of the following as needed:

- Any third-party payer having responsibility for payment of charges for treatment
- Review agents or auditors
- Managed care or utilization review agents

Please confirm your insurance information below and/or provide a copy of your insurance card:

Insurance Carrier Member ID#

Group # Provider Service Phone

Relationship to Primary Insured

Primary Insured Name Primary Insured Birthdate

I understand that I may revoke this consent at any time and that I may inspect and copy the information disclosed. I further understand that I can invalidate this consent any time before the expiration date so long as I submit revocation in writing to the Practice. Finally, the agency reviewing the clinical information and/or records will be advised not to disclose my records to any other agency/person without my written informed consent.

Assignment of Benefits: I hereby assign, transfer and set over Clinical Care Consultants, my rights and interest to reimbursement benefits under my insurance policy. I understand that I am financially responsible to Clinical Care Consultants for charges not covered by this assignment.

Signature Date