WAUKESHA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
RELEASE OF INFORMATION FOR BILLING PURPOSES

PATIENT INFORMATION				
LAST NAME	**FIRST**	**MI**	**SEX**	**DOB**

STREET ADDRESS	**CITY**	**COUNTY/TRIBE OF RESIDENCE**	**STATE**	**ZIP**

HOME PHONE #	**CELL PHONE #**	**GUARDIAN / RESPONSIBLE PARTY**	**RACE**	**MARITAL STATUS**

I _____ hereby authorize the release of any and all information necessary to process claims for services rendered during treatment beginning on the admission date below. I give consent to the Waukesha County Department of Health & Human Services (WCDHHS) to disclose and release my medical and treatment records to a third-party payer, such as my health care plan, for payment, claims reimbursement and third party appeal purposes. I understand that this may include substance use records bound by Title 42 CFR Part 2. I also consent to the disclosure and release by WCDHHS of my insurance eligibility and subscriber information to the Provider and/or their billing agent for medical services rendered to me prior to (or during my involvement in) treatment services with WCDHHS. I further authorize payment directly to WCDHHS, who accepts my assignment. This information is confidential and limited to the above purposes only.

EXPIRATION DATE: This authorization will expire 24 months following the completion of active services with WCDHHS unless a specific date is _____ or a written notice of revocation is submitted.

☐ **HEALTH INSURANCE WAIVER FOR NON-COVERED SERVICES:** I understand that WCDHHS will bill my commercial, Medicare, and/or Medicaid insurance as a courtesy. I understand that my health insurance may not cover certain services provided by WCDHHS, and that I may be responsible for non-covered services. I understand that I am responsible to pay applicable deductible, co-payment, and/or co-insurance amounts. I understand that it is my responsibility to verify benefits with my insurance company.

☐ **UNINSURED WAIVER FOR RENDERED SERVICES:** I understand that I will be responsible to pay any applicable fees for any rendered services in accordance with Wisconsin Administrative Code DHS1.

☐ **REDSTAMP PROGRAM (MEDLIST):** I understand the Redstamp Program is subject to the above statements. Additionally, I understand that I am responsible for any copays associated with my Genoa Pharmacy prescriptions.

Signature of Patient or Power of Attorney or Guardian or Legal Representative * Date

Signature of Witness Date

* If signed by a person other than the client, complete the following:

Client is: ☐ Minor ☐ Incompetent ☐ Unable to sign due to disability

Legal Authority: ☐ Parent of Minor ☐ Legal Guardian ☐ Power of Attorney (POA)

☐ Other: _____

* If you check any of the above boxes, you must have proof of legal authority (i.e. Guardianship Papers, Power of Attorney documents) *

OFFICE USE ONLY

ATTENDING DOCTOR	ED VOL	MRN	ADMISSION DATE/TIME	DISCHARGE DATE/TIME

PATIENT'S SS# _____ **SUBSCRIBER'S NAME** _____

PRIMARY INSURANCE CO NAME _____ **ID #** _____ **GROUP #** _____

SECONDARY INSURANCE CO NAME _____ **ID #** _____ **GROUP #** _____

TERTIARY INSURANCE CO NAME _____ **ID #** _____ **GROUP #** _____

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