

Authorization for Disclosure of an Individual's Health Information

Subscriber or Dependent Whose Information is to be Disclosed:

Name				Policy #	
Street Address	City	State	Zip	Daytime Phone Number	

Person(s) or Entity(ies) to Whom Information May Be Disclosed

Brent Eley Foundation dba Brent's Place, Lynnda Simpson, Allen Browning
11980 E 16th Ave, Aurora, CO 80010 Phone: 720-343-2802 or 720-343-2800 Fax: 303-831-4567

Information to be disclosed by _____ at the request of the individual authorized to do so. (Insurance Company)

- Health Plan Benefit Information: Includes information contained in your benefit booklet (i.e. copayments, coinsurance, eligibility and other benefit information).
- Claims Information: Includes information related to payment of your claims for services you received, including pertinent information located on a claim form (i.e., billed amount, claim payment, denial reason, etc.)
- Authorization Information: Includes information regarding precertification and authorization, including specific medical information related to requests and determinations.
- Other: please specify: _____

Length of Time for Which This Authorization is Valid

Under applicable law, this authorization is valid up to 24 months (or a shorter period of time if so indicated) or for a particular event that has occurred, as stated in the authorization. This authorization will remain in effect until:

- 24 months from the date of signature of this authorization
- Until _____, but no longer than 24 months from the date of signature.

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect the ability to obtain treatment, payment or eligibility for benefits. However, there may be some consequences with the intended recipient of this information.
- I understand this authorization is not valid without the required signature.
- I understand that I have the right to revoke this authorization at any time in writing, except to the extent that my insurance company has already provided the information.
- I understand that the recipient of this information may possibly re-disclose the information to others without my knowledge or authorization therefore; the privacy law may no longer protect my information.

I authorize billing and payment directly between the within named Insurance company and Brent's Place.

Print Full Name	Signature	Date
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Relationship/Authority: Please check one. Member Parent of Minor Child
Please provide documentation if you are: Power of Attorney Legal Guardian

**BRENT'S PLACE
APPLICATION FOR FAMILY ASSISTANCE**

Please provide additional information describing your financial situation:

Clinical Social Work Assessment:
