Substance Abuse Treatment Medical Authorization Release Form

(for Addiction Insurance Coverage)

Patient Information

Full Name

Date of Birth

Address

Phone Number

Insurance Provider

Member/Policy Number

Authorization

I hereby authorize the release of my medical records and information concerning my treatment for substance abuse to the insurance provider listed above for the purpose of insurance coverage, benefit determination, and claim processing. This authorization includes, but is not limited to, records regarding diagnosis, prognosis, and treatment plans.

Information to be Released

Provider/Facility Name

Provider/Facility Address

Patient Rights & Acknowledgment

- I understand that this authorization is voluntary and I may revoke it in writing at any time.
- I understand that once the information is released, it may no longer be protected by federal privacy regulations.
- I understand that refusing to sign this authorization may affect my insurance coverage for addiction treatment.

Authorization Effective Date

Authorization Expiration Date

Patient Signature

Date

Witness/Representative Signature

Date

If signed by a legal representative, indicate relationship to patient: