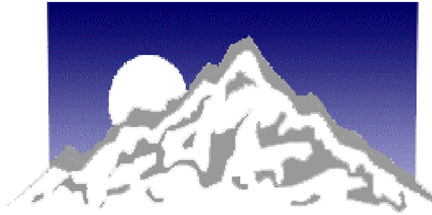

Mat-Su Health Services, Inc
1363 W Spruce Avenue
Wasilla, AK 99654
(907) 376-2411

Multi-Party Billing Consent Form

Name: ______________________________________ Date of Birth: _____________
(Name of individual whose information is to be disclosed)

I, ____________________________________, authorize Mat-Su Health Services to disclose to the following individuals or entities:

- Health benefit programs (such as Medicare, Medicaid, Third party insurance plans) in which I am, or may become enrolled in;
- The individual or individuals who is (are) the responsible party(ies) for payment for services;
- Mat-Su Health Services' collection agency, attorney(s), and the courts in the event of a default on payments.

The following information including, but not limited to:

- Demographic information;
- Assessment and diagnostic information;
- Treatment recommendations, planning, and review information;
- Treatment services, notes and records.

For the purpose of:

- Determining and/or establishing eligibility;
- Making and processing claims for payment;
- Utilization review activities.

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent expires automatically when the account is paid in full, or I terminate treatment, whichever occurs later.
Note: Failure to sign this authorization or exercising the right of revocation may result in the suspension of services – unless alternative payment arrangements are worked out in advance.

_____________________ _________________________________
Date Signature of Person Requesting Services

____
Signature of parent, guardian, or authorized representative