KENDALL COUNTY HEALTH DEPARTMENT

Assignment of Benefits / Release of Healthcare Information

Assignment of Benefits

I, ____________________________, authorized payment of medical benefits to Kendall County Health Department.

(Patient's/Guardian's/Policy Holder's name)

____ ________________________________

(**Patient's/Guardian's/ Policy Holder's Signature**) **Today's Date**

Release of Healthcare Information

I, ___________________________ , acting on behalf of ___________________________ , here authorize the release

(**Patient's/Guardian's/Policy Holder's name**) (**Patient 's name)**

of Healthcare information.

My Healthcare Information

Name of Insurance Carrier:

(Please mark all that apply)

- □ Aetna
- □ BCBS PPO
- □ BCBS Community Health
- □ Beacon Health Options
- □ Cigna
- □ Compsych
- □ Humana
- □ Illinicare/YouthCare
- □ Magellan
- □ Medicaid
- □ Molina
- □ UHC/OPTUM
- □ WellCare
- □ Other, please specify

____

Information that may be released:

(Please mark both)

- □ Diagnosis
- □ Treatment

I understand that I have the right to revoke this consent in writing at any time and that I have the right to copy and inspect the information being disclosed.

It has been explained to me that if I refuse to consent to this Release of Information specified above, the following might occur **may impede services**.

Patient's/ Guardian's/Policy Holder's Signature _____________________________ **Today's Date** _______________

Revised 10/20/2020