Iowa Department of Human Services

Authorization to Release Information for Assignment of Insurance Benefits

TO: The Superintendent of the Mental Health Institute, , Iowa.

This is your full and sufficient authority to release my name and any other confidential information needed to obtain reimbursement for the cost of my care and treatment from any third party payers or funding sources. (This includes MAGELLAN.)

I hereby assign to the Mental Health Institute and the state of Iowa any and all insurance benefits due me to cover the cost of my care in the institute.

Dated this day of , 20

THIS CONSENT EXPIRES ONE YEAR FROM ABOVE DATE

Witness	Signature of individual, parent, guardian, or legal representative
	If not the individual, your relationship to patient

The information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

MENTAL HEALTH INSTITUTE	STAMP PATIENT IDENTIFICATION IN SPACE BELOW
AUTHORIZATION TO RELEASE INFORMATION FOR ASSIGNMENT OF INSURANCE BENEFITS	