Release of Confidential Information and Consent to Bill

Child's Name:	Date of Birth:
Parent/Legal Guardian Name:	**Phone #:**

My signature below indicates that Florida's Early Steps Written Notice Related to Release of Confidential Information and Consent to Bill have been provided and explained to me.

My responses below will indicate whether the Early Steps Program is authorized to release my confidential information and use my private and/or public insurance to pay for services included in my child's Individualized Family Support Plan (IFSP). However, each time there is an increase in the frequency, length, duration, or intensity of the service, a new consent must be provided for private insurance.

For individuals with **both** private and public insurance, authorizing or declining the consent to use their private and public insurance will be applied equally. Therefore, if consent for private insurance is authorized, the family also authorizes the use of their public insurance. Alternatively, if consent for private insurance is denied, the family also denies the use of their public insurance.

Families have the right to withdraw their consent to release confidential information or to bill at any time.

Check applicable box for consent to release confidential information. Please note that consent to release confidential information is required for billing.

☐ Yes, I provide consent to release confidential information	☐ No, I do not provide consent to release confidential information
☐ Yes, I provide consent to release confidential information but not to the following entities:	

Check applicable box for consent to bill services to private and/or public insurance.

☐ I do not have private or public insurance
☐ I decline consent to bill all applicable services to private and/or public insurance
☐ I provide consent to bill all applicable services to private and/or public insurance
☐ I provide consent to bill all applicable services to private and/or public insurance except for the specific services listed below, which I decline to bill to private insurance

Declined Services:	

I agree that if an Explanation of Benefits and payment for services on the IFSP is sent to me rather than to the provider, I will submit the payment to the Local Early Steps Office.

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire on my child's third birthday.

RE-DISCLOSURE: I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that services will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to my service coordinator. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Signature **Date**

Insurance Information

Plan Name	Start Date	End Date	Subscriber's Name	Subscriber's Member ID