ATTACHMENT II

Lakes Regional Healthcare

CONSENT TO RELEASE OF INFORMATION TO COUNTY OF RESIDENCE

I, the undersigned, understand that I will receive or have received the above healthcare facility and at the time of treatment, I either have/had no insurance coverage, and/or am not aware of any insurance coverage, commercial or otherwise, to which the healthcare organization may submit claims on my behalf for the purpose of obtaining payment and/or related benefits for my healthcare treatment. I also affirm that I am not eligible for Indian Health Service benefits nor am I a member of a Native American tribe and thus Indian Health Services and/or the Bureau of Indian Affairs are not potential resources for the hospital to submit claims for my healthcare treatment on my behalf. I also affirm that I have not served in any branch of the military for any period of time, or if I have served in a branch of the military, the healthcare that I am receiving is not eligible or covered by the Veteran's Administration.

I understand that I may or may not have the personal financial resources to pay the costs for healthcare treatment and care as recommended by my attending/treating physician and as such, this form is being signed by me to authorize all persons, agencies, or institutions (including this healthcare organization and my physician(s)) to release to the welfare director, auditor, states attorney, and/or county commissioners of my county of residence, information concerning my social security number, medical information concerning my healthcare treatment, and financial information concerning me and/or members of my household. This information will be required by my county of residence to process benefits on my behalf for which I may be eligible.

By signing, I indicate that I fully understand this Consent to Release of Information, and am voluntarily signing below.

Dated this _____day of _____, year.

_____	_____
*Patient Social Security Number	*County of Residence
_____	_____
*Patient	Patient Representative
_____	_____
*Witness	Witness
_____	
*Account #	

***Required**