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Authorization to release information to insurance company for payment.

Client Name: _____

Birth Date: _____ Social Security Number: _____

I, REQUEST AND AUTHORIZE, Keira Oseroff TO:

- 1) Release and Request information to my insurance company.
- 2) Seek Payment from my mental health benefits.

(INSURANCE COMPANY)

(ADDRESS)

(CITY/STATE/ZIP)

(PHONE) _____ (FAX) _____

Please Note: Benefit verification is not a guarantee of payment by your insurance company.

Information released may include mental health privileged or confidential information, alcohol, drug or other treatment information. Certain communications are privileged and not subject to release without your consent under state and/or federal law.

After considering the above statement, I authorize Laura Graham to furnish information regarding my treatment to the above insurance company. I also agree to hold harmless Laura Graham from all liability that may arise from the release of information requested.

I understand that this authorization may be revoked by me at any time, except when information released in accordance with state or federal law.

Date Signed

Client Signature

Parent Signature/ (Legal Guardian if applicable)