Authorization to Use/Disclose Information to Insurance Companies

Client Name: ____ | **Date of Birth:** _______________________________

Name of Guardian *(if applicable)*: __________________________

Insurance Company: ____

Name of Policy Holder: ________________________________ | **Policy Holder Date of Birth:** _____________________

Policy/ID Number: ______________________________________ | **Group Number (if applicable):** __________________

Primary Care Physician: _________________________

This release is good for the duration of your current insurance, or the duration of your current therapy here, whichever is shorter.

I, ______________________________________, authorize the release of any information to my insurance company when necessary to process my claims.

I, ______________________________________, authorize payments under my insurance programs to be made directly to the above provider for any services furnished by this provider. This authorization may be relied upon when transmitted by fax.

I, ______________________________________, authorize the Protected Health Information to be transmitted by fax. I understand that unless action already has been taken in reliance on this authorization I may revoke this authorization at any time by making a verbal or written request. I understand that my express consent is required to release any information related to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually-transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use. This information has been disclosed from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit anyone from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. All information and records, whether publicly or privately maintained, that identify a person who has AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions of this Article shall be strictly confidential. (G.S. 130A-143.)

Signature: ____ **Date:** _____________

Guardian Signature (if applicable): ____ **Date:** ____________

Witness: ____ **Date:** _____________

Please email a copy of your insurance card to office@blackmountaincounseling .org

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