



Authorization to Use and Disclose Protected Health Information (PHI) to Insurance

It is required by law to obtain a client's authorization to disclose PHI to Insurance. Please fill this form out completely.

Client Name: _____ Date of Birth: _____
Address: _____ Social Security # _____
City, State, Zip: _____

I authorize Hannah Fischer, MA, LPC Counseling to send Information to:

Insurance Company: _____ Subscriber _____
ID or SSN#: _____ Group/Policy # _____

The purpose of this disclosure is to bill insurance for the client mentioned above.

The information to be released is: Treatment Plan, Course of Treatment, Diagnosis, Psychosocial History, Other: _____

Required Statements:

I understand that the information used or disclosed may be subject to re-disclosure and no longer protected under law.

It is not required that you sign this authorization. Refusal will not negatively affect your ability to receive mental health treatment from Hannah Fischer, MA, LPC, LMHC. If you do not sign it, your health insurance will not be billed. Clients then are required to pay with Cash or Check at the regular rate (which can be discounted in cases of need). You may revoke this authorization at any time in writing. At that point, the information may no longer be disclosed. Any use or disclosure already made cannot be undone. To revoke this authorization, please request the form to do so and return it to Hannah Fischer, MA, LPC, LMHC.

This written authorization is subject to revocation by the undersigned at any time, except to the extent that action has been taken. This authorization will expire 6 months from the signed date. Other (specify): _____

Client Signature _____ **Date** _____

Counselor Signature _____ **Date** _____