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RELEASE OF CONFIDENTIAL INFORMATION: INSURANCE COVERAGE

Your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis and dates of treatment. I may be required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record.

By signing this document you:

- authorize me to contact and to give your insurance company the information they require in order for them to pay for services that I provide you
- authorize your insurance company to make payments directly to me
- acknowledge that once the information has left my office I have no control over the confidentiality of your records and no control over how the insurance company will handle your records.

Patient Name: ______________________ Date: ________ Signature: ______________________