HIDDEN SPRINGS PSYCHOLOGICAL SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION
BY HIDDEN SPRINGS PSYCHOLOGICAL SERVICES
FOR BILLING PURPOSES ONLY

I agree to authorize _____ to release any information from my file required by the billing source(s) listed below regarding my psychological treatment and services.

This authorization for release of the above information is to be in effect through: _____ unless otherwise revoked.
(Date Not to Exceed 1 Year)

1. _____
   Name of Insurance Co.

2. _____
   Name of Insurance Co.

Please let us make a copy of the appropriate insurance card(s).

I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED BY ME AT ANY TIME.
I UNDERASTAND THAT I HAVE THE RIGHT TO REVIEW ANY INFORMATION PRIOR TO IT BEING RELEASED.

Client Name: _____ _____
Date of Birth

Signature: _____ _____
Client, Parent, Guardian, Authorized Person Date

Witness: _____ _____
Date

REVOCATION OF AUTHORIZATION

I hereby **REVOKE THIS AUTHORIZATION** for billing purposes.

Client Name: _____ _____
Date of Birth

Signature:_____ _____
Client, Parent, Guardian, Authorized Person Date

Witness: _____ _____

Date