Counseling & Consulting, LLC

Psychological Consulting

Consent to Release Confidential Information to Insurance Company

Client Name (Print):_____

This release is good for the duration of your current insurance, or the duration of your current therapy at Counseling & Consulting LLC whichever is shorter.

I authorize the release of any information to my insurance company when necessary to process my claims. I also authorize payments under my insurance programs to be made directly to the provider, Selia Servín-Eischen, PsyD, LMFT.

I agree that if the amount is insufficient to cover the bill, I will be responsible for payment of the difference and if my treatment is not covered by my insurance policy, I will be responsible to the provider for the entire amount.

I further permit copies of this authorization to be used in place of the originals.

Please not the following points regarding confidentiality:

(a) This information has been disclosed to you from records whose confidentiality is protected by state and federal law. Federal regulations (42 C.F.R. Section 2.31 (a) and 2.33) and state regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. Federal and state rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

(b) Please restrict the availability of these records to those in your employment who have the training and experience to interpret and understand the information contained in them. This ethical and perhaps legal responsibility is yours.

_____ _____

Client / Guardian Signature Date