AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FOR PAYMENT AND REIMBURSEMENT PURPOSES

LITTLE BIRD PSYCHOTHERAPY, P.S., INC

Client Information *Please print legibly.*	Name*_____ Date of Birth*_____ Other Names Used:_____ Phone #:_____ Parent/Guardian/Legal Representative Name (where applicable)_____
Insurance Company Information/TPA With **whom** may Little Bird Psychotherapy (LBP) share your information?	_____ Name of Insurance Company/Third Party Administrator* _____ _____ Phone Number Fax Number _____ Address (street, city, state, zip code) *Required Field
Communication ***How** will LBP share your information?*	I authorize Little Bird Psychotherapy to exchange the information indicated below by verbal communication, or by sending and requesting paper copes via US mail or fax.
Information to be Released ***What** is to be released?* **Please check all that apply.**	I authorize Little Bird Psychotherapy to release ALL information and records pertaining my treatment, including but not limited to: Intake Evaluations/Diagnostic Assessment Nutritional Documentation Medical Documentation/Labs Substance Use Disorder Records Individual Therapy Documentation/Progress Notes Administrative Records (e.g. appointment listings, billing) Treatment Plans Discharge Summaries Genetic Information HIV/AIDS Records Psychiatric Documentation ___Other (please specify)_____
Purpose of the Release of Information **Why** is the release needed?	I understand the purpose of this release is to file, process, and support insurance claim(s), obtain authorization, communicate information needed to substantiate the claim, and participate in the review process to determine medical necessity for my level of care and continued treatment.

Statement of Authorization: I understand that:

- I may revoke this consent at any time, except to the extent that Little Bird Psychotherapy has already acted in reliance on it, by providing oral or written notice to Little Bird Psychotherapy at the address noted in the Notice of Privacy Practices. If I revoke this authorization, I will be responsible for payment in full of all my treatment costs to the extent they are not otherwise paid on my behalf. **This consent automatically expires three (3) years after my last date of service at Little Bird Psychotherapy.**
- I have been informed what information will be released, its purpose, and who will receive the information, and I may inspect or copy the protected health information to be used or disclosed under this authorization per applicable state and federal laws.
- I understand that any substance use disorder treatment and diagnosis records are protected under federal regulation 42 CFR Part 2 and disclosure is allowed only with this specific authorization, except in limited circumstances as stated in LBP's Notice of Privacy Practices and Informed Consent.
- Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from substance use disorder records. However, HIPAA requires LBP to notify me that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA.
- I understand that I may refuse to sign this authorization. LBP will not condition treatment based on whether I sign this authorization. I understand that if I refuse to sign this authorization, I am electing to self-pay for services at LBP as specified in the Financial Responsibility Agreement.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THIS AUTHORIZATION FORM AND AUTHORIZE LITTLE BIRD PSYCHOTHERAPY TO RELEASE THE ABOVE SPECIFIED INFORMATION TO THE PARTY IDENTIFIED ABOVE FOR THE REASON IDENTIFIED ABOVE.

Client Signature* Parent/Guardian/Representative Signature **Date**

*Age of consent for **mental health records** is 13 years old in the state of Washington, clients 12 years old and younger must have Parent/Guardian consent.
*Age of consent for **substance abuse records** is 12 for outpatient, 18 for residential in the state of Washington.

Legal Representative (where applicable): I am legally authorized to represent the client listed above and I understand that I may be asked to provide documentation to demonstrate this legal authority.

Legal Guardian/Representative Signature Relationship to Client/Legal Authority **Date**