Complementary Out of Network Billing, Form 2 of 2:

HIPAA Authorization to Use & Disclose Protected Health Information

1. I am completing this form to allow the use and sharing of protected health information of **(PRINT the full names of ALL clients):** ____
____

2. I authorize Flourish Counseling & Coaching, LLC to use or disclose the following information:

3a. Please check all that may apply:

- ☐ Treatment records for physical and or psychological, psychiatric, or emotional illness.
- ☐ Intake and termination summaries.
- ☐ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations.
- ☐ Social, family, educational, and vocational histories.
- ☐ Progress notes or similar notes.
- ☐ Evaluations and reports of consultants.
- ☐ Academic and educational records, including tests results, reports of teachers' observations, and all other school or special education documents.
- ☐ HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here.

X All billing information including diagnoses, dates of service, and types of service.

- ☐ Do NOT release these.
- ☐ Complete copy of the medical record.
- ☐ Other: ____

3b. Dates of care included: From ______________ to ___________________________.
(Date of First Session) **(Date 1 Yr After First Session)**

4. To this person(s) or organization(s):

____
(List the name of your health insurance company here)

5. The information will be used/disclosed for the following purposes:

To assist you in accessing any Out of Network benefits available on your plan.

6. I understand and agree that this Authorization will be valid and in effect for 180 days or until I revoke it in writing, whichever occurs first. I understand that after that event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

7. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any disclosures after the date it is received but can not change the fact that some information may have been sent or shared before that date.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from this professional.

9. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.

10. I understand that if the person or entity that receives the information is not a health care professional or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

12. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

TO BILL FOR COUPLES THERAPY THE SIGNATURES OF BOTH PARTNERS ARE REQUIRED:

____ ______________

13. **Signature of adult client or parent/guardian** **Date**

____ ______________

Signature of adult client or parent/guardian **Date**

14. I acknowledge that I received a copy of this completed form.

Submit this form WITH the "My Health Insurance Info" form.