

## Insurance Authorization

I, \_\_\_\_\_ [Insert Name of Patient/Client], whose Date of Birth is \_\_\_\_\_, authorize Mary St. Clair, MSW, 3674 Oakleaf Rd., West Bloomfield, MI 48324 to provide my health or auto insurance company with the following information:

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

_____ Assessment	_____ Educational Information
_____ Diagnosis	_____ Discharge/Transfer Summary
_____ Psychosocial Evaluation	_____ Continuing Care Plan
_____ Psychological Evaluation	_____ Progress in Treatment
_____ Treatment Plan or Summary	_____ Demographic Information
_____ Current Treatment Update	_____ Other _____
_____ Presence/Participation in Treatment	_____ Other _____

Purpose

The purpose of this information is to obtain insurance payments for services provided by Mary St. Clair, MSW

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Mary St. Clair at 3674 Oakleaf Rd. West Bloomfield, MI 48324. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this consent expires on the following date: \_\_\_\_\_ or as otherwise indicated: \_\_\_\_\_

Conditions

I further understand that Mary St. Clair, MSW will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

\_\_\_\_\_

I will be given a copy of this authorization for my records.

\_\_\_\_\_  
Signature of Patient/Client Date

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

\_\_\_\_\_ Check here if patient/client refuses to sign authorization

\_\_\_\_\_  
Signature of Staff Witness Date