Marna Reed, M.A., L.P.
1710 Douglas Drive suite 275
Golden Valley, MN 55422

Authorization for Release of Information-Health Insurance

Some health insurance companies provide coverage for mental health services. If you elect to use Insurance to cover some of the cost of your therapy, with your consent, I will bill the Insurance Company and provide "Protected Health Information" (PHI) needed to make a determination about the claim. Thy types of information most commonly required are described below. Although rare, it is possible that your insurance company will request copies of psychotherapy notes describing the content of your sessions. Be advised that I have no control over how PHI is handled by your insurance company. If you have concerns, please contact your insurance company and ask about their privacy policies.

I, _____ authorize Marna Reed, M.A., L.P, to disclose to my Insurance Company, _____, information needed to process my insurance claim, including my name, name of the insured, address, phone number, date of birth, identification number, policy and group numbers, dates and cost of services, and information about the psychologist providing these services. Other information that may be required includes a summary of my treatment plan, diagnosis, symptoms, progress, prognosis, and functional status.

I understand that no additional information will be released, except for that which is otherwise authorized by law, and that access to this information will be limited to persons whose work assignments reasonably require such access to accomplish the purposes stated above (e.g. my billing person). I understand that I may revoke this consent, although not retroactively.

I authorize payment of medical benefits to Marna Reed, M.A., L.P for services described on claim forms.

Client _____
Date of Birth _____
Insured Name _____
Client's Relationship to the Insured:
Self _____Spouse/Partner _____Child_____
Insured Date of Birth _____
Insured ID# _____
Annual Deductible _____

Insurance Company _____
Insurance Phone _____
Insurance Address_____
_____
Insurance Group _____
Authorization ID_____
Authorization Effective Date _____
Session Co-Pay _____

Secondary Insurance Information

Signature of client(s) or guardian

Date

_____

_____