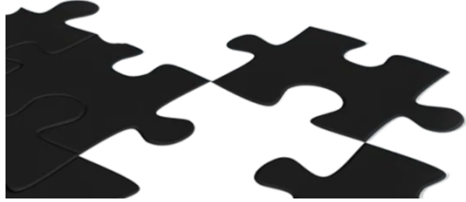
CT ABA SERVICES LLC
11 BOTSFORD RD.
SEYMOUR CT, 06483



TJG@CTABASERVICES.COM
(203)906-5328

HIPPA & Insurance Release

Insurance Company Name: ___________________________
[Address]
[City, State, Zip Code]

RE: Insurance Information Release Form and HIPAA Waiver Request

Dear Sir/Madam,

I am writing to request the release of my insurance information and to provide consent for the disclosure of my protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA). I am a policyholder with your company, and I understand that this information is essential for various purposes, including medical billing and claims processing.

Please find below the details of my request:

Policyholder Information:

Name: ____

Date of Birth: ____________________

Policy Number: ______________________

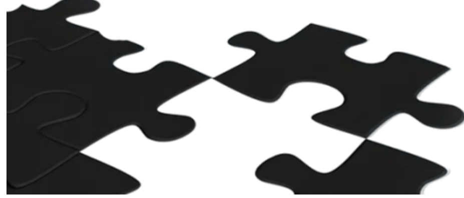
Social Security Number:______________________________

Address:____

____

Authorization for Insurance Information Release:
I authorize [Insurance Company Name] to release the following information to the authorized recipients listed below:

Type of information to be released: All insurance policy details, claims history, and billing information.



_ and its members

HIPAA Authorization:
I hereby authorize the disclosure of my protected health information (PHI) to the following healthcare providers, insurance companies, and other entities, as necessary for the purpose of processing medical claims and providing healthcare services:

Healthcare Provider's Name: ____

Insurance Company Name: [Insurance Company Name]
Any other entity or individual involved in my medical care or insurance claims process: [List Additional Names and Entities]
Effective Period:
This authorization is effective immediately and remains in effect until [Specify Date/Event if Applicable] or until I revoke it in writing. I understand that I have the right to revoke this authorization at any time by providing written notice to [Insurance Company Name].

Additional Terms and Conditions:
I understand that the information disclosed may be subject to re-disclosure by the authorized recipients and may no longer be protected by federal privacy regulations. I release [Insurance Company Name] and its agents from any liability arising from the disclosure and use of my insurance and PHI information as authorized herein.

Signature:
By signing below, I acknowledge that I have read and understood the terms and conditions of this authorization, and I voluntarily authorize the release of my insurance information and protected health information as specified above.

Signature: ___________________________ Date: ______________
Witness (if applicable):
If the requester is unable to sign due to a physical or mental condition, the following individual may witness the signature:

Witness's Name: _______________________ Date: ______________

Witness's Address: ______________________ Phone Number: _________
Please process this request at your earliest convenience. You may contact me at the provided phone number or email address if you require any further information or clarification regarding this request.

Thank you for your prompt attention to this matter.

Sincerely,

Authorization to Release Information

Clients Name: _____________________________

Date of Birth: ___________

I understand this release is voluntarily and applies to all programs and services operated under the supervision of CT ABA Services LLC.
I hereby authorize CT ABA Services LLC to (check all that apply)

____ Exchange information with ______________________________________

____ Release information to ____

____ Obtain information from ____

The Following organization/individuals regarding the above-named patient:
Name of organization/individual

____

Address: ____
City: ____________________State: _________ Zip: ___________
Phone: ________________________
I hereby authorize this information to be exchange in the following manner(s):
____ Verbal Only
____ Written form only
_x_ Both Verbal and written communication
Description of information to be exchanged/released/obtained (select all that apply)
__x__ Education Records
__x__ Evaluation/assessments/eligibility records
__x__ Medical Records

____Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)
Other:
____

This information is to be used for diagnostic, treatment planning and continuity of care purposes only.

This release will remain effective for two (2) years, unless otherwise stipulated and revoked in writing. From _________________(MM/DD/YYYY) To _______________(MM/DD/YYYY)

_________________________ __________________
Parent/Guardian Printed Name Date

____
Parent/Guardian Signature

Records Release By: __________ Dated Released: ___________