Counseling Associates of Rockford

HIPAA Notice of Privacy Practices

Consent and Assignment
(Release of Information)

I, _____, hereby authorize Brian Klaung, LCSW, Colin Gillette, LMFT, or designee(s) to release and disclose such medical records, information, and documentation as may be necessary or appropriate in order to process insurance claims; to provide treatment plan updates to managed care programs as requested; and to obtain payment on my behalf. I also authorize the release of information acquired in the course of my assessment or treatment and all information pertaining to my history and progress of my case. I agree that a photo-copy of this, my original, shall be considered equally authentic. I understand that this may include sensitive diagnosis, (i.e., mental health, developmental disabilities, alcohol/drug abuse, and/or AIDS/HIV). I understand that this consent allows this information to be released orally or through copies of medical records to my insurance company or compensation carrier.

I agree to hold harmless Brian Klaung, Colin Gillette, or designee, against any and all liability damages, claims, or suits, including reasonable attorneys' fees in connection with the disclosure of information, including reports, as consented herein.

I acknowledge that I have received a copy of Brian Klaung's Notice of Privacy Practices describing my rights as a patient of Brian Klaung and/or Colin Gillette, and describing Brian Klaung and/or Colin Gillette's obligations regarding the use and disclosure of my health information.

I understand that I am responsible for notifying my insurance company to obtain authorization before service is provided if required by my insurance. I understand that if I do not pre-certify my treatment or obtain required referrals, I may cause a reduction of benefits payable to Brian Klaung, LCSW, and I will be liable for that loss or reduction in benefits.

I assign payment of medical benefits to Brian Klaung, LCSW, for services described. I understand that I am financially responsible for charges not covered plus any and all costs incurred in or related to the collection of such charges including but not limited to, reasonable collection agency charges of 30% of the account balance due.

_____ _____

Patient Signature Date

_____ _____

Guardian Signature (if patient is a minor) Date

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