11920 Sawhill Blvd., Spotsylvania, VA 22553
Ph 540-317-1165 Fax 540-301-5657

Authorization to Release or Exchange Information

I, _____authorize information to be released or exchanged with the following parties:

INSURANCE COMPANY _____
Address _____
_____
Phone _____Fax_____
ID# _____ Group # _____

NOTE: Your name and payment information will be entered into my billing system which is secure and password protected. Your information is only accessible by me or those I authorize to service my billing. In accordance with HIPAA regulations I must inform you that with this signed release, I am authorized to send information to your insurance company required for appropriate reimbursement to include diagnosis, progress summary, treatment plans and service codes if requested. Reports are typed professionally and thus may be viewed by an administrative support person. I may use fax to communicate with you or your insurance company and may contact you by cell phone.

OTHER (family members, physicians, employers)

Name_____
Address_____
Phone_____Fax_____
Type of Information _____

Client Name (Please Print) _____

Client Signature _____

Legal guardian signature (if applicable) _____

Effective Date _____ Expiration Date _____

**If you have any questions please feel free to ask me about this policy. You may rescind your acceptance of this Release of Information at any time by providing a request in writing to Marie T. Anderson, MA, LPC at 11920 Sawhill Blvd., Spotsylvania, VA 22553.