DEBRA K. SOWALD, PSY.D.
PSYCHOLOGIST
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(937) 434-6840

Individual, Family, & Group Therapy
Psychological Assessment
Imagery & Senoi Dreamwork

AUTHORIZATION TO RELEASE PHI FROM DR. SOWALD FOR INSURANCE BILLING

Client Name _____ S.S. # _____
Birth Date_____

This form when completed and signed by you, authorizes Dr. Sowald to release protected health information from your medical record to your insurance company and their designated utilization review, managed care, and/or claims payment subdivisions and/or business associates.

I authorize Dr. Sowald to release the following information:
_X__ Assessment and Diagnostic Impression X__ Treatment Plan and/or Outcome _X__
Medications Used and Response to the Medication
_X__ Assessment of Client's Substance Use/Abuse and Recovery
_X__ Client Identifying Information
_X__ Recommendations for Follow-Up
_X__ Psychosocial History
_X__ Admission Summary
_____Other_____
_X__ Treatment Dates and Times
_X__ Indicators of Progress
_X__ Psychological Evaluation
_X__ Discharge Summary

This information should only be released to the Following Insurers and/or their Designees:
_____
_____
_____

I am permitting Dr. Sowald to release this information for the purpose of utilizing my medical benefits to help with payment on my account for professional services rendered by Dr. Sowald.

This authorization shall remain in effect until all claims have been settled.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the above office address. However, your revocation will not be effective to the extent that Dr. Sowald has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Also, revocation of this consent will render the signee and/or guardians responsible for payment in full on this account.

I understand that Dr. Sowald generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

(over)

I release Dr. Sowald from any legal liability resulting from the release of this information with the understanding that Dr. Sowald will exercise reasonable professional safeguards regarding this information.

I have read and understand this document.

Signed this _____ day of _____, 20_____

Signature of Client_____

Signature of Parent or Guardian, if applicable

_____

Signature of Witness

_____

A TRUE PHOTOCOPY HEREOF MAY BE CONSIDERED AS AN ORIGINAL