***Core Counseling and Coaching, LLC***

Donald A. Burroughs, MA, LPC

1751 South Lumpkin Street

Athens, Georgia 30606

706-725-9255

**Authorization Form for Insurance Companies and other Third Party Payers**

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person(s) you designate.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize my counselor Donald Burroughs, MA, LPC to release my personal health information (PHI).

This information should only be released to my insurance company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I am requesting my counselor to release this information for the purpose of meeting insurance company requirements for payment of treatment. This authorization shall remain in effect until I no longer wish to use insurance benefits.

I retain the right to revoke this authorization, in writing, at any time by sending such written notification to Donald Burroughs’ office address. However, revocation will not be effective to the extent that action has already been taken on this authorization or if this authorization was signed as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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 HIPPA Privacy Rule.

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Signature of Client or Legal Representative Date

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Signature of Counselor Date