SELF EXPRESSIONS

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AUTHORIZATION FOR RELEASE OF HEALTH INSURANCE INFORMATION

I give permission for Self Expressions to bill my health insurance for my treatment.

NAME OF HEALTH INSURANCE:_____

EXPIRATION: This authorization will expire at the end of treatment or after Self Expressions is paid for services rendered.

REVOCATION: I understand I may revoke this authorization at any time by telling my therapist.

I understand that once protected healthcare information is disclosed it may be disclosed again by the recipient and may not be protected by federal privacy laws and regulations.

Signature of Client:_____ **Date**:_____
(or of Parent/Guardian if client is a minor)