ANNA HEDLY GOEKE, M.A., LMFT

Authorization to Use and Disclose Protected Health Information (PHI) to Insurance

It is required by law to obtain a client's authorization to disclose PHI to Insurance. Please fill this form out completely.

Client Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____

Phone #: _____

( ) Do not bill my insurance
Rate for Self Pay client is $_____ per 50 minute session

( ) Bill my EAP
EAP copay of $_____ per 50 minute session ($0 if not applicable)

( ) I authorize Anna Hedly Goeke, MA, LMFT, to send Information to:
( ) Primary Insurance ( ) Secondary Insurance (Please use one form for each)

I authorize Anna Hedly Goeke, MA, LMFT, to send Information to:

Insurance Company: _____

Insurance Co Phone #:_____

Subscriber Name: _____

Subscriber ID: _____ Subscriber Date of Birth: _____

Relationship to Patient: _____ Group/Policy #:_____

The purpose of this disclosure is to bill insurance for the client mentioned above.
The information to be released is: Treatment Plan, Course of Treatment, Diagnosis, Psychosocial History, Other:

_____

Required Statements:
I understand that the information used or disclosed may be subject to re-disclosure and no longer protected under law. You may revoke this authorization at any time in writing. At that point, the information may no longer be disclosed. Any use or disclosure already made cannot be undone. This written authorization is subject to revocation by the undersigned at any time, except to the extent that action has been taken.

Client (or Guardian) Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

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