Puyallup Psychotherapeutic Alliance

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:

Social Security #:

I authorize Puyallup Psychotherapeutic Alliance to send information to:

Insurance Company:

Subscriber ID:

Subscriber DOB:

Group/Policy #:

Required Statements:

I understand that the information used or disclosed may be subject to re-disclosure and no longer protected under law. It is not required that you sign this authorization. Refusal will not negatively affect your ability to receive mental health treatment from Psychotherapeutic Alliance. IF you do not sign this form, insurance will not be billed. Clients would have to pay with cash, check or credit card at time of visit. To revoke this authorization, please put all the above information as well as your reason for revocation in writing and return to Anahita Armin at Puyallup Psychotherapeutic Alliance. Any use or disclosure already made cannot be undone.

Client Signature: Date:

Therapist Signature: Date: