**AUTHORIZATION TO SUBMIT CLAIMS, ASSIGN BENEFITS AND REQUEST AND/OR RELEASE INFORMATION TO HEALTH INSURANCE COMPANIES:**

Having been fully informed of the policies and procedures of Tsipporah Kohen LCPC regarding the authorization and/or request

for release and re-release of protected health information, as stated, I/we _______________________________________ hereby authorize the following regarding
(Client, parent, guardian)
________________________________________________________________________________.
(Client and date(s) of birth)

1. Tsipporah Kohen to submit claims for services provided to me/us to

__________________________________________________; (Health plan)

2. My health plan named above to release and re-release to Tsipporah Kohen information regarding insurance benefits or processing claims and Tsipporah Kohen to release to my health plan named above any medical/social work or other information necessary to process claims and Tsipporah Kohen to release to my health plan named above any medical/social work or other information necessary to process health insurance claims, which may include diagnosis, type of service, treatment plan, and progress regarding the client named above.

3. Tsipporah Kohen and my health plan named above to specifically release and re-release drug and alcohol information to each other. (**Please initial here**: ______)

4. The payment of benefits from my health plan named above to make on my behalf to Tsipporah Kohen for any services furnished by that supplier.

I understand that this Information is to be used only for the following: for submitting health insurance claims. IN THE EVENT THAT MY INSURANCE COMPANY REIMBURSES ME DIRECTLY, I WILL FORWARD THAT PAYMENT IN ITS ENTIRETY TO TSIPPORAH KOHEN. This authorization will be valid until _______________, unless I/we revoke it in writing prior to that date.
(date)

I/we understand that I/we may revoke this consent at any time. I/we understand that this information may be released by TSIPPORAH KOHEN prior to its receipt of any processing of a revocation. I/we may inspect and copy the information to be disclosed.

It has been explained to me/us that a refusal to consent to this release of information will not affect my/our receiving services from Tsipporah Kohen.

I VERIFY the signature below is mine and may be kept on file.

_________________________________________________________________________________

**(Signature of client) (WITNESS) (Date)**

_________________________________________________________________________________

**(Signature of adult if client is under 18) (WITNESS) (Date)**