CATAWBA COUNSELING ASSOCIATES, PLLC

Victoria V. Grantham, M.S.W.

523 Keisler Dr., Suite 103
Cary, NC 27518
704-829-2005
704-829-2006(f)

Authorization for release of information and assignment of health insurance benefits.

Patient's full name: _____DOB: _____

Patient's address:_____

I, _____hereby authorize Catawba Counseling Associates, PLLC, Cary, NC to furnish confidential information from my/the patient's medical and/or psychiatric records to:

Insurance company name: _____ID# _____

Address _____ City, State, zip _____

Health insurance carrier, including their consulting health professionals and utilization review organization.

Insured's name_____Insured's SSN_____Insured's DOB _____

Group name _____ Group number _____

The information requested is diagnosis, additional treatment planning, progress and summary information as requested by the insurance carrier and approved by the responsible treated for the purpose of obtaining legitimate insurance benefits. This consent is subject to revocation at any time, except to the extent that Catawba Counseling Associates, PLLC has already taken action in reliance on it. If not previously revoked, this consent will terminate upon the completion of a continuous period of treatment and collection of related health insurance benefits.

Authorization to pay benefits:

I hereby authorize payment directly to Catawba Counseling Associates, PLLC of any insurance or other benefits payable as a result of the patient's treatment and the undersigned hereby assigns to Catawba Counseling Associates, PLLC his and/or her rights to collect such benefits directly from the carrier. Notwithstanding the above, the undersigned understands that he and/or she remains responsible for the payment of any charges which are not paid by insurance. Moreover, the undersigned recognizes that this contractual obligation to pay for services rendered shall not be affected by any third party payer's determination relating to the reasonableness of charges or the medical necessity of the services rendered to the patient.

Signed this _____day of _____, 20 _____ .

Signature of patient (or responsible party) _____

Present Address _____City, State, Zip _____

Witness signature _____

Signature of parent, guardian, or authorized representative _____

Present Address _____City, State, Zip _____

Nature of relationship _____

Alcohol and drug abuse patient records

Confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibit any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose (see Rule 2.32 (a)).