AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (V. P/SA)

Client Name _____ Client ID No. _____

Person or Organization Disclosing the Information:

The ITM Group

Person or Organization Receiving the Information:

_____

_____

Specific Description of the Information to be Disclosed:

Any and all information related to the above named client's account, billing information, collections, or financial status with The ITM Group.

The purpose of this request is:

Allow The ITM Group, it's administrative and accounting departments, to address issues related to the above named client's account and or communicate with the above named person(s) related to any issue connected to the client's account. This is to include billing, collections and the refunding of any money owed to the client or the above named person(s).

This authorization will expire on: Date: _____ OR when the following occurs: six months following the termination of services with The ITM Group.

I hereby authorize the use or disclosure of my protected health information as specified above. This authorization permits disclosure of only information about financial and accounting records related to my case. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. Other limitations on my right to revoke this authorization may be found in my provider's Notice of Privacy Practices. I understand that, if the recipient is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient.

I understand that treatment may not be denied if I refuse to sign this authorization, except if the authorization is the very reason for seeking the health care (e.g., a pre-employment physical), that health care may be denied. In addition, the following consequences might occur if I refuse to sign this authorization: (1) If the authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it; and (2) If the authorization is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to authorize disclosure of certain psychotherapy notes.

_____ _____

Signature of Client Date

Signature of Legal Guardian / Relationship to Client: _____