Authorization for Release of Information

I, _____, whose Date of Birth is _____,

authorize the Provider signing below to disclosed and/or obtain from Valley Therapy Services, Inc. DBA Valley Billing the following information: Diagnosis Code(s), Insurance Information, Demographic Information and Dates of Service. The purpose of this disclosure of information is to share information relevant to billing insurance for services rendered, including: Verifying insurance eligibility and benefits, Submitting claims to insurance for services received and Insuring that proper payment is made by insurance companies.

Revocation:
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Provider at the address above. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration:
Unless sooner revoked, this authorization expires at the termination of treatment with Provider.

Form of Disclosure:
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure:
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.). _____

_____Check here if patient/client refuses to sign authorization

_____

Signature of Provider Date