

Psychological and Consultation Services, P.C.
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CONSENT TO RELEASE INFORMATION FOR MEDICAL AUTHORIZATIONS

I understand, as a member of _____ (insurance company), my treatment will be periodically evaluated for continued payment for services. I am authorizing such disclosure.

Failure to authorize disclosure of treatment will result in unauthorized sessions by your insurance company, which could lead to higher co-payments or you are being responsible for the payment of sessions.

Therefore, I authorize Psychological and Consultation Services (PCS), 4123 Okemos Rd., Ste 15, Okemos MI 48864 to provide the above information to be used for the following purposes: payment of services by my insurance company.

Use of this consent to release information is effective from the date it was signed until the patient informs us, in writing, of any changes to this consent.

I understand this release may be revoked at any time by written notification to the organization holding the information, except after the release described above has taken place.

Patient's Signature/ Parent or Representative's Signature

Date

Signer's Relationship to Patient