Sharmaine D. Barnes, LMFT

2529 W March Ln., Ste 104 Stockton, CA 95207-8270
Tel: (209) 475-8428 Fax: (209) 475-8479
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Authorization to Disclose Protected Health Information to Insurance Company

Communication between your behavioral health provider(s) and your Insurance Company is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with your Insurance Company. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider.

The Patient

Last Name	First Name		Middle Initial
Date of Birth (MM/DD/YYYY)	Phone Number	Subscriber Number From ID Card	Insurance Company Name
Street Address		City, State and Zip Code	

The following behavioral provider may disclose the information:

Name Sharmaine D. Barnes, LMFT	Phone Number (209) 475-8428	Fax (209) 475-8479
Street Address 2529 W March Ln., Ste 104	City, State, and Zip Code Stockton, CA 95207-8270	

Who Will Be Receiving Information About the Individual?

Name	Phone Number (if known)	Fax (if known)
Street Address (if known)	City, State, and Zip Code (if known)	

What Information About the Individual Will Be Disclosed?

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

The Purpose of the Disclosure

To release behavioral health evaluation and/or treatment information to the Insurance Company for coordination of care, payment, other.

The Expiration Date or Event

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date.

Important Rights and Other Required Statements You Should Know

™You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
™The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
™You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
™This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
™You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

Patient Signature_____ Date (required) _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.