AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
CONSENT TO RELEASE/RECEIVE INFORMATION - INSURANCE BILLING

Patient Name_____

Person or Organization Disclosing the Information:	Person or Organization Receiving the Information:
Beth Sikora, Ph.D.	Insurance company and any and all agents,
6501 E. Greenway Pkwy, #103-529	employees, financial officers, managers and
Scottsdale, AZ 85254	officers, and anyone necessary to collect fees, if necessary.

Specific Description of the Information to be Disclosed:

Treatment plan, diagnosis, dates and length of sessions, symptoms, method of treatment, your name, address, phone number, date of birth, social security number, family names and employers, if applicable, and their social security number, your cooperativeness in treatment, risk factors, medication, prior treatment, and other information required by a managed care or insurance company.

The purpose of this request is: Bill for payment of treatment

This authorization will expire on: Date _____ 1 year _____ OR when the following occurs:

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I hereby authorize the use or disclosure of my protected health information as specified above. This authorization permits disclosure of information **about mental illness or substance abuse conditions, as well as other health conditions** and information. I understand that his 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: (1) If the authorization is the very reason for seeking the health care (e.g. a pre-employment physical), that health care may be denied; or (2) If the authorization is for disclosure to a research study, I may be denied the treatment that is part of the study. 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; (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; and (3) Dr. Sikora cannot bill any insurance carrier for my treatment.

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Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient: _____