Kolpia Counseling Services
607 Siskiyou Blvd. Ashland, OR. P: (541)482-1718 F: (541)482-0964

Authorization for Release of Information for Billing Insurance

Client: _____ DOB: _____

I am currently participating in an outpatient substance use treatment program at Kolpia Counseling Services. The purpose of this release is:
____ to facilitate communication with my insurance company

It is understood by my signature below that Kolpia Counseling Services and the person and/or organization listed will be exchanging information concerning me.

This Authorization for Release of Information is to:

Name, Address, Phone, & Fax of Insurance:

Name of Insurance Provider	Address	City	St	Zip

Phone _____ Fax _____

The information I authorize to be released is:

INITIAL

____Personal Information Required for Billing

____Level of Care

____Medical Diagnosis/Treatment

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you 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.

This consent is good until the end of treatment.

_____

Client Signature _____Date _____

Counselor Signature _____Date_____

Code 42 CFR Part 2 prohibits the re-disclosure of information concerning clients in alcohol and drug abuse treatment.

Revised 3-2017