Consent to Release Information to Insurers/Payers

I authorize Heather Roselaren, LCSW/MPH to share billing information with, and to bill, the insurance company, government program or person named below for services to :

(name of the client--usually you): ____

under my coverage or other payment arrangement with:

(insurance company or payer): ____

I also assign to Heather Roselaren, LCSW/MPH, the payments for the sessions for which she bills on my behalf.

This authorization shall become effective immediately and shall remain in effect for (choose one:)

[_] duration of treatment [_] 1 year [_] until this date: ___________________.

Signature of Client: ____

[if signing on behalf of client, relationship to client: _______________________]

Date Signed: ____

Date Printed: ____