# Billing & Scheduling Release

**Is there anyone other than yourself who might:**
**Make payments on your account?**
**Make/change/cancel appointments for you?**

**If yes, please fill out this release form.** By signing this form you will authorize us to share your billing and/or scheduling information with the individual(s) you specify.

I, _____ authorize Pike Creek Psychological to do the following:
(your name here)

*Please check the box that corresponds to the information you would like PCPC to share. You may check one or both.*

**SHARE MY BILLING INFORMATION**

☐ I authorize PCPC to:
- **release** information about my account to the individual(s) I specify below.
- **request** from the individual(s) I specify below any information necessary to allow payments to be made on my account.

**SHARE MY SCHEDULING INFORMATION**

☐ I authorize PCPC to:
- **release** information about my appointments to the individual(s) I specify below.
- **request** from the individual(s) I specify below any information necessary to allow changes to be made to my appointments.

**To whom should we release/From whom should we request your information?**

Name:_____

Relation:_____

**The purpose of this authorization is to provide you, the client, with our services in a manner convenient for you.**

**This authorization will expire one year from the date it is signed.**

- You have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However, your revocation will not be effective to the extent that PCPC has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
- If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.
- I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.
- However, any disclosure of information that pertains to the treatment or diagnosis of drug abuse or alcohol abuse or a referral for such treatment or diagnosis, and which would identify a patient as an alcohol or drug abuser, permitted hereunder shall be accompanied by the following written statement: "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."
- Any facsimile, copy, or photocopy of this authorization shall have the same effect of the original.

Client name:_____ DOB:_____

Signature:_____ Today's date:_____

Office Use Only: Entered in MDC? ☐

Admin initials & date: _____