PARKER COLLINS
FAMILY MENTAL HEALTH

1056 Centerville Circle | Vadnais Heights, MN 55127
Phone 651.604.7771 | Fax 651.426.8116

Release of Information Authorization to Bill Third Party

Client name:		**Client DOB:**	

I (we) authorize Parker Collins Family Mental Health, LLC to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to:

_____
Third-party payer or insurance company

for the purpose of receiving payment directly to Parker Collins Family Mental Health, LLC. I understand that access to this information will be limited to determining insurance benefits and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I understand that I may revoke this consent at any time by providing written notice and that after one year this consent expires. I have been informed what information will be given, its purpose, and who will receive it. I certify that I have read and agree to the conditions and have received a copy of this form.

_____ _____
Signature of Person(s) Responsible for Payment of Account Date

_____ _____
Signature of Person(s) Receiving Services Date

_____ _____
Signature of Parent / Guardian Date

Rev. 5/2014