Denise E. Turner, LICSW, LCSW

CONSENT TO RELEASE INFORMATION TO INSURANCE COMPANY OR THEIR DESIGNATED MANGAEMENT ORGANIZATION

This document provides the authorization for the release of relevant information to your insurance company or to their designated management or review organization if one exists. This information may be required in order to authorize treatment or services to pay benefits.

_____ _____ _____

Client Name Date of Birth SS#

_____

Client Address City State Zip

_____

Client Phone

I, the undersigned, hereby authorize Denise E. Turner, LICSW, LCSW to send information:

Primary Insurance: _____Subscriber:_____

Address:_____

ID or SS#_____Group Policy #_____

Phone ( )_____DOB: _____

_____ _____

Signature Date Signed

Responsible Party (if different from primary insured):_____

SS#_____DOB: _____

Address: _____

_____ _____

Signature Date Signed

This authorization for release covers all dates of treatment.

This written consent is subject to revocation by the undersigned at anytime, except to the extent that the action has been taken in reliance heron. If not earlier revoked, or by other agreement specified below, this consent shall expire one year after termination of treatment.

Your signature below will authorize the insurance companies to make payment directly to Denise E. Turner, LICSW, LCSW.

_____ _____

Signature of client, parent or legal guardian Date Signed

_____ _____

Denise E. Turner, LICSW, LCSW Date Signed

Denise E. Turner, LICSW, LCSW
Release of Information

I, _____ whose Date of Birth is _____,

authorize Denise E. Turner, LICSW, LCSW to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

(Please initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_____
_____Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other than marketing, sale of information, research or as specified above, please specify: _____
_____

Marketing

- □ If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by Denise E. Turner, LICSW, LCSW in exchange for disclosing the information.$_____

Sale of Information

- □ If the purpose of this disclosure is for the sale, license to use or lease of the information, please check this box.

Research

- □ If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study.

  _____.