

Julie A. Hanson, Psy.D., PLLC

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Edmonds, WA 98026

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Release of Information for Third Party Reimbursement

I _____ hereby authorize the mutual release/ exchange of information concerning myself/my minor child between Julie A. Hanson, Psy.D.

and _____ as may be necessary for the following (your insurance company)

purposes only:

1) For use by insurance company(ies) for processing claims for treatment and/or for requesting the authorization of additional sessions, including the release of PHI, diagnosis, and clinical information.

2) Other: _____

Dr. Hanson may bill the following insurance company(ies) and they may pay her directly:

Company: _____ ID Number: _____

Group Number: _____

Company: _____ ID Number: _____

Group Number: _____

I assign directly to Dr. Hanson all medical benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance.

Parent/Client signature: _____ Date: _____

Client signature: _____ Date: _____

Julie A. Hanson, Psy.D., PLLC Date: _____