Ellen N. Emerson, Ph.D.

Licensed Psychologist Georgia #2041

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## Authorization to Use and Disclose Protected Health Information (PHI) to Insurance

Client Name: ___________________________________ DOB_________________________________

Street Address: _____________________________________________________________________

City, State, Zip Code: _______________________________________________________________

Telephone Number: _________________________ Social Security Number: ______________________

I, the undersigned, hereby authorize Ellen N. Emerson, Ph.D., and its contracted billing representatives to send information to:

Insurance Company ___________________________ Subscriber: _____________________________

ID Number: __________________________________ Subscriber SSN: _________________________

Group/Policy #: _______________________________ Subscriber DOB: _________________________

Secondary Insurance ___NO ___YES

Insurance Company ___________________________ Subscriber: ___________________________

ID Number: _________________________________ Subscriber SSN: _________________________

Group/Policy #: ______________________________ Subscriber DOB:_________________________

**Required Statements:**

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AID, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment from Ellen N. Emerson, Ph.D., unless the health care services are solely for the purpose of providing health information to someone else and the authorization is needed to make the disclosure. I understand that Ellen N. Emerson, Ph.D., will not be able to bill my insurance. I will be required to be Self Pay based on the fair and customary rate for all mental health treatment at Ellen N. Emerson, Ph.D.

I may revoke this authorization in writing at any time. If I do so, the information described may no longer be used or disclosed for the purposed described in this written authorization. Any use or disclosure already made cannot be undone. If I revoke this authorization, I understand I will enter into the Self Pay arrangement described above as Ellen N. Emerson, Ph.D. will not be able to bill my insurance. This written authorization is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon.

I have read this authorization and understand it. I have also received a copy of the Privacy Policies:

_____________________________________________ ________________

Signature of Patient Date

_____________________________________________ ________________ _________________________

Responsible Party Signature if Client is a Minor Date Relationship to Client