



Release of Appointment Times and Billing Information

Client Name (printed)

Client Date of Birth

AUTHORIZATION TO RELEASE APPOINTMENT TIMES AND BILLING INFORMATION
PLEASE REVIEW CAREFULLY

You have the right to request restriction of your protected appointment time and billing information at any time.

You may request that we communicate your appointment times and billing information in person or over the telephone to family member, relatives, or friends. If you request this right, we are required to have a completed authorization on file prior to releasing your information.

I AUTHORIZE THE INDIVIDUALS LISTED BELOW ACCESS TO MY APPOINTMENT TIMES AND BILLING INFORMATION:

Name (printed)

Relationship

Phone Number

Name (printed)

Relationship

Phone Number

Name (printed)

Relationship

Phone Number

You may revoke or change this authorization at any time with written notice.

I have received the Seasons Counseling of Michiana's Notice of Privacy Practices and understand that my appointment times and billing information may be used by the Practice as described in the notice.

Client Signature

Date

We are here to help.