Magill Psychotherapy, LLC
2011 Commerce Dr N F109
Peachtree City, GA 30269
404-953-5279
magillpsychotherapy@gmail.com
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Authorization for Release of Information

I, _____ (hereafter "Client") hereby authorize Kara Magill, LCSW/Magill Psychotherapy, LLC (hereafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment including but limiting to therapist's diagnosis of Client to: *(list insurance company below)*

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless provider has taken action in reliance upon it. I understand that such revocation must be in writing and received at **2011 Commerce Dr. N F109 Peachtree City, GA 30269**

This disclosure of information and records authorized by client is required for the following purpose:

Insurance Claim Submission/Billing Date of Service/Diagnosis & ICD Codes/Verification of benefits

The specific uses and limitations of the types of information to be discussed as follows:
Insurance Claim Submission/Billing/Date of Service/Diagnosis & ICD Codes/Verification of benefits

Such disclosure shall be limited to the following specific types of information:
Purposes of Insurance Claim Submission Only/Billing Only/ Date of Service/Diagnosis & ICD Codes Only /Verification of benefits Only_____

Client has the right to refuse to sign this authorization.
Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy Rule., although applicable Georgia Law may protect such information.
This authorization shall remain in effect until: _____
(1 year from today's date)
Client's Signature_____ Date: _____