Christy Anderson Jacob, Ph.D

Licensed Psychologist

INSURANCE RELEASE AUTHORIZATION

Client Name _____ Relation to Subscriber _____

Address _____ Birthdate _____

_____ Phone (home) _____

(work) _____

Subscriber Name _____ Birthdate _____

Address _____ Phone (home)_____

_____

Insurance Carrier _____

Address: _____ Member ID #: _____

_____ Group #:_____

Medical Assistance #: _____ Exp. Date: _____

I hereby authorize _____ (psychologist) to furnish the above-named reimburser/insurance carrier with the information that I am presently receiving treatment services and with the following data: a statement of my diagnosis, the services I receive, the person(s) providing and supervising these services, and the dates on which the services were provided. The insurer will use this information to determine reimbursement for services provided.

I understand that no other information will be released and no other uses will be made of this information, except for those previously communicated to me or as otherwise authorized by law, and that access to this information will be limited to persons whose work assignments reasonably require access to accomplish the purpose stated above. I understand that I may revoke this consent in writing at any time.

_____ _____

Signature Date

_____ _____

Signature of Witness (if minor) Date

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Arden Hill, MN 55112

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