Counseling and Consultative Services, LLC
LaVerne M. Kalafor, EdS, LCSW, CCHt
Authorizations

Authorization to Release Information:

I authorize the release of any medical or other information necessary to Counseling and Consultative Services for the processing of insurance claims. This includes PHI information for billing services or/as related to business activities (e.g. therapy appointment reminders).

_____ _____
Signature Date

Authorization to Pay Benefits to Provider:

I authorize payment of benefits directly to LaVerne M Kalafor, EdS, LCSW dba Counseling Consultative Services LLC, for the services provided. Where applicable, I also request payment of government benefits to the party who accepts assignment.

_____ _____
Signature Date

Authorization of Communication:

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. HIPPA law grants you authority to deny certain individual from receiving information except required by law.

I authorize communication regarding treatment services, appointments or needs by
Home phone, cell phone, email, voice mail, answering machine, emergency contact or next of kin listed **except for the following** individuals:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Locations: _____ Phone: _____

Locations: _____ Phone: _____