Authorization/Release of Information

I, _____, whose Date of Birth is _____, authorize the staff of
Name of Patient/Client
PeoplePsych LLC, to disclose to and/or obtain billing related information from:

_____
Name & Contact Info of Person or Title of Person or Organization

Purpose
The purpose of this disclosure of information is solely to address and respond to billing related inquiries or issues related to services rendered by PeoplePsych LLC to client named above.

Revocation
I understand that I have a right to revoke this authorization at any time by notifying PeoplePsych LLC in writing at 111 N Wabash Ave., suite 1203, Chicago, IL 60602. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this consent expires on one year from the date signed.

Conditions
I further understand that PeoplePsych LLC and its agents will not condition my treatment on whether I give authorization for the requested disclosure.

However, it has been explained to me that failure to sign this authorization will result in neither my therapist or PeoplePsych LLC representative being unable to discuss billing issues with identified other and patient/client will assume financial responsibility for ongoing care.

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure
State and Federal law prohibit the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by Federal and State laws.

I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records.

_____
Signature of Patient/Client Date

_____
Name Patient/Client (Printed)