

**Authorization for Disclosure of Mental Health Information
To My Insurance Company**

I authorize Susan M. Williams, LISW, LLC to release mental health information, to the full extent specified under Iowa Code Chapter 228, or as subsequently amended, to my insurance company and to any organization contracting with this insurance company to:

1. Administer claims submitted or to be submitted for payment
2. Conduct a utilization and quality control review of mental health care services provided or proposed to be provided, or
3. Conduct an audit of claims paid.

I acknowledge that I may inspect the information disclosed at any time, and may revoke this authorization at any time if I furnish written revocation to Susan M. Williams, LISW, LLC. In the event I revoke this authorization, I agree to accept financial liability, in writing, for mental health care services provided if my insurance company or its affiliates or subsidiaries deny claims for benefits because of the inability to examine my mental health records.

This Authorization for Disclosure pertains to _____
Client name and date of birth

Client or legal guardian of client, above

Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTIFICATION

Check one option:

____I have received a copy of the Privacy of Information Policy from Susan M. Williams, LISW, LLC, as requested by law.

____I have been offered a copy of the Privacy of Information Policy from Susan M. Williams, LISW, LLC and have declined.

Client/person legally responsible for client's consent:

(please print)_____

Signature_____Date_____