**Debra Gibbons M.S., LMFT**

**321 N. Mall Dr. Bldg. O, #101, St. George, Utah 84790**

**Telephone: (435) 868-8376 Fax: (435) 635-9720**

**Encrypted e-mail** [**www.schedule.care**](http://www.schedule.care) **or debra.gibbons@gmail.com**

**RELEASE OF CONFIDENTIAL INFORMATION-INSURANCE**

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Hereby give my permission for Debra Gibbons to release information to (insurance company name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Information to be released may include assessment/evaluation results, diagnosis, attendance and participation records, treatment plan and progress and recommendations to coordinate benefits for the above stated client. I also give my permission for the above insurance company to release payment for mental health benefits directly to Debra Gibbons. Failure to sign this authorization, in and of itself, is not sufficient grounds to deny mental health treatment.

I understand that my records are protected by law under the Federal and State Confidentiality

Regulations and cannot be disclosed without my written consent. I understand that I may revoke this consent at any time except to the extent that disclosure action has already been taken. I also understand that this consent expires 12 months after discharge from treatment.

I also acknowledge that the information to be released was explained to me and that this consent is given of my own free will. I also understand that if I am not willing to sign a release for insurance purposes that Debra Gibbons, MS, LMFT, will collect cash only for her services.

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Signature of Client Date Signature of Parent/Guardian Date

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Debra Gibbons MS, LMFT Date

FDA Requirements PROHIBIT REDISCLOSURE of PHI because of the potential risk to the client. The information disclosed to you has been disclosed from records whose confidentiality is protected by Federal Law. Federal Regulations 42 CFR, Part 2 prohibits you from making further disclosure without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of mental health is not sufficient for that purpose.

To revoke release of information sign and date below and it is revoked as of the date signed.

Signature of Client Date Signature of Parent/Guardian Date