ERIN LIEBMAN
School Psychologist, Reading Specialist, Licensed Clinical Professional Counselor

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ______________________________, give permission to Erin Liebman (LCPC), to release the following information: Dates of treatment, types of treatments, symptoms being treated, diagnosis, and any additional information necessary to process claims with Blue Cross Blue Shield of Illinois, Aetna, or Cigna Insurance Company. The purpose of this communication is for the processing of insurance claims/billing services. A copy of this agreement shall have the same effect as its original form. In addition, this release will expire at the duration of the therapeutic relationship, or expressed written consent of the client.

Disclosure:

There may be no re-disclosure of this information without the expressed written consent of the client; however, understand that the possibility of re-disclosure by the recipient may occur, in which case the information is not protected by federal law.

________________________________ ___________
Client Signature Date:

________________________________ ___________
Witness Date:

Revocation:
This release of information may be revoked at any time by signing below; however, Erin Liebman is not liable for the information released prior to this date.

________________________________ ___________
Client Signature Date:

________________________________ ___________
Witness Date: