# CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

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Person or Organization Granted this Consent:
Dan Bernard, M.A., L.P.C., N.C.C.
Resolution Counseling Services

With this consent form, I am requesting your explicit permission to disclose protected health information from your record to your insurer, so that I might file claims for my services on your behalf for your reimbursement and to request additional sessions as needed. By signing this consent, you are giving me permission to use or disclose your protected health information and other information required for this activity and authorizing a copy of this form to be used in place of the original for that purpose.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

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I hereby consent to the use or disclosure of my protected health information and other required information as specified above.

________________________________________
Name of Patient

________________________________________ ________________________
Signature of Patient Date.

____________________
Patient Date of Birth.

Filename: insurance
Directory: J:\060320_2209 (D)
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