8280 College Parkway, Suite 103
Fort Myers, FL 33919

RELEASE OF INFORMATION
(for Third-Party Payment Only)

At times, an important aspect of counseling is coordination with other individuals, community agencies, your family, or any other providers you may have worked in the past. It is also necessary at times to communicate with insurance companies to facilitate reimbursement.

Please sign the statement below giving your permission for me to communicate with these individuals or agencies on your behalf:

Responsible Party for Billing: ______________________________

I/We hereby give consent to **SWFL Counseling, LLC** to release or receive information regarding my treatment (or my child's treatment), deemed necessary, to or from other individuals or service providing agencies concerning:

Information related to billing only: signed Release of Information, Third-Party Payment Authorization, and/or billing statement (contains no confidential treatment information)

I/We understand that all information involved will be kept confidential from person(s) not authorized.

Signed: ______________________________
Client

____
Client

____
Witness (Counselor)

Date: ______________________________

*A photocopy of this authorization shall be considered valid.