**Erik Bohlin, M.A., LMHC**
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## AUTHORIZATION FOR USE OR DISCLOSUREOF PROTECTED HEALTH INFORMATION FOR PURPOSES REQUESTED BY THIRD-PARTY PAYERS

**Type of Information to be Disclosed:**
I hereby authorize **Erik Bohlin, M.A.** to use and/or disclose any protected health information required to process manual and electronic insurance claims to my insurance company. I authorize my insurance benefits to be paid directly to the provider and acknowledge that I am responsible for any balance due. I agree that I will not withhold or delay payment because of any insurance/third-party involvement.

**Recipient of Protected Health Information:**

**Name of Insurance Company** ❑ Blue Cross (Premera) ❑ Blue Shield (Regence)

❑ Blue Cross/Blue Shield ❑ Lifewise ❑ Value Options (Boeing)

| Name of Insured (Subscriber) | Subscriber ID # | Group # |
|---|---|---|
| Date of Birth of Insured | Name of Patient | Birthday of Patient |

**Deliver By:** Mail or electronic billing.

**Revocation / Redisclosure:**
It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already occurred based on prior authorization, and/or including provision of health care services requiring disclosure to effectuate payment. Unauthorized redisclosure by recipient is a potential risk.

**Duration:**
Length of time needed for completion of payment for services given to client.

**Signature:**
This Authorization covers protected health information pertaining to ___BILLING___________.

Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the date of that signature. I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment or eligibility for benefits. There is no guarantee that your insurance company will pay for your sessions, and you are responsible for your bill whether or not your insurance pays. I hereby assign payment of insurance benefits directly to: Erik Bohlin, M.A., P.S.

Signature (Patient / Parent / Guardian /Other legal representative for health care decisions) Date

Witness Date

Thank you for filling this form out to us. You can are welcome to fax it back to us at 425-368-3738.