P.O. Box 3244
Inuvik, NT X0E 0T0
Phone: (866) 708-3501
E-mail: admin@impressions-counselling.org
WEB: www.impressions-counselling.org

AUTHORIZATION TO COMMUNICATE PROTECTED HEALTH INFORMATION TO INSURANCE

IMPRESSIONS FAMILY COUNSELLING SERVICES (IFCS)

Your signature on this form will authorize IFCS to receive and/or disclose private information about you. Health Information is protected by Federal and Provincial law and by IFCS policy. Do not sign this authorization unless it is completed in full and in your interest.

Client Name: _____ Date of Birth: _____
Address: _____ Social Insurance No.: _____
City: _____ Province: _____ Postal Code: _____

With my signature below, I authorize IMPRESSIONS Family Counselling Services to send information to:
Insurance Company: _____ Subscriber: _____
AB Health Care No.: _____ Group Policy No.: _____

Purpose for the disclosure:
☒ Authorization to bill insurance named above

Information to be released: ***(Information to be disclosed MUST be initialed)***

_____☒ Psychological history
_____☒ Psychological evaluation or reports
_____☒ Diagnosis
_____☐ Other: _____
_____☒ Progress Notes
_____☒ Chemical dependency information
_____☒ Treatment plan or summary

This authorization will expire:
_____☒ 90 days after completion of treatment and insurance and client payment in full

REQUIRED STATEMENTS:
You do not need to sign this authorization. Refusal to sign the authorization will not prevent you from receiving mental health and/or drug/alcohol treatment at IMPRESSIONS Family Counselling Services, unless the health care services are solely for the purpose of providing health information to someone else and the authorization is needed to make the disclosure.

If you do not sign this authorization, IMPRESSIONS Family Counselling Services will not be able to bill your insurance. Clients will be required to pay based on a fair and customary rate for all mental health and/or drug/alcohol treatment at IMPRESSIONS Family Counselling Services.

You may end this authorization in writing at any time. If you revoke your authorization, the information described may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made cannot be undone. To revoke this authorization, please request the form from our office staff or your therapist. Complete the form and return it to IMPRESSIONS Family Counselling Services.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure and no longer protected under Federal and/or Provincial law. However, I also understand that Federal or Provincial law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment or referral information.

Client (or personal representative) signature: _____ **Date**: _____
*(*Client signature required if over 14 years of age)*

Subscriber's signature: _____ **Print Name:** _____
*(*Ages 14 to 24, subscriber must sign form or if client is a dependent on insurance policy)*

- If signed by a personal representative of the client, please complete the following:
  Printed personal representative's name: _____
  Authority of personal representative: □ Parent □ Legal Guardian □ Power of Attorney/Healthcare □ Other: _____