567 Park Avenue, Suite 204
Scotch Plains, NJ 07076

3322 Route 22 West, Suite 1401
Branchburg, NJ 08876

O: (908) 242-3634
Tax ID: 81-5115434
NPI: 1619414885

BRAVE MINDS
psychological services

Release of Information for a Third Party Payer

Authorization for Use and Disclosure of Protected Health Information for Billing and Payment

This form provides authorization to Brave Minds Psychological Services LLC to use or disclose certain of your personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. You should carefully read the information on this form before signing it.

Client Full Name: _____

Client Date Of Birth: _____

Name of individual providing authorization and signing this document:

_____

Relationship to Client

- ☐ Self
- ☐ Guardian

If you wish to file claims with an insurance provider, you should be aware that your contract with your health insurance company requires that we provide information relevant to those services. In order to obtain reimbursement through the Victims of Crime Compensation Office (VCCO) or an Employee Assistance Program (EAP), they will also require that BMPS provide the information relevant to those services. For example, we would be required to provide a clinical diagnosis in order for you to file claims and we might be required to provide additional clinical information such as treatment plans or summaries. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files (or VCCO's/EAP's) and will probably be stored in a computer. Though all insurance companies (and VCCO/EAP) claim to keep such information confidential, we have no control over what they do with this information once it is in their hands.

BRAVE MINDS
psychological services

567 Park Avenue, Suite 204
Scotch Plains, NJ 07076

3322 Route 22 West, Suite 1401
Branchburg, NJ 08876

O: (908) 242-3634
Tax ID: 81-5115434
NPI: 1619414885

Client Full Name & Date of Birth: _____

Expiration

This authorization shall expire in 365 days OR upon written revocation OR the occurrence of the following:

_____

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to the Practice's Privacy Officer at Brave Minds Psychological Services LLC, 567 Park Avenue, Suite 204, Scotch Plains, New Jersey 07076.

I understand that if my records contain information about HIV/AIDS status, I authorize Brave Minds Psychological Services LLC to release such information as part of my medical record.

I understand that a revocation is not effective to the extent that Brave Minds Psychological Services LLC has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance 0. Release of Information for a Third Party Payer coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.

I understand that Brave Minds Psychological Services LLC will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences of me denying authorization.

I understand there is the potential for information used or disclosed pursuant to this authorization to be subject to re-disclosure by the recipient if the recipient is not required by law to protect the privacy of the information. I understand that I will receive a copy of this authorization if signed by me.

BRAVE MINDS
psychological services

567 Park Avenue, Suite 204
Scotch Plains, NJ 07076

3322 Route 22 West, Suite 1401
Branchburg, NJ 08876

O: (908) 242-3634
Tax ID: 81-5115434
NPI: 1619414885

Client Full Name & Date of Birth: _____

By authorizing this Agreement, you agree that we can provide requested information to your insurance company and/or the Victims of Crime Compensation Office or EAP.

You always have the right to pay for services yourself, and can avoid the problems described above by not filing for reimbursement.

Authorization to disclose information for payment purposes:

- ☐ I hereby authorize the use or disclosure of my health information as described in this form.
- ☐ I hereby do NOT authorize the use or disclosure of my health information as described in this form.

If applicable,

Guardian Name: _____

Guardian Relationship: _____

Guardian Signature: _____

Client (18+) Signature: _____

Today's Date: _____