Interplay
Counseling Services

Authorization for Disclosure of Mental Health Information
To My Insurance Company

I authorize Susan G. Schmitz, LISW, Inc. d/b/a Interplay Counseling Services to release mental health information, to the full extent specified under Iowa Code Chapter 228, or as amended, to my insurance company and to any organization contracting with this insurance company to:

1. Administer claims submitted or to be submitted for payment
2. Conduct a utilization and quality control review of mental health care services provided or proposed to be provided, or
3. Conduct an audit of claims paid.

I acknowledge that I may inspect the information disclosed at any time, and may revoke this authorization at any time if I furnish written revocation to Susan G. Schmitz, LISW, Inc. d/b/a Interplay Counseling Services. In the event I revoke this authorization, I agree to accept financial liability, in writing, for mental health care services provided if my insurance company or its affiliates or subsidiaries deny claims for benefits because of the inability to examine my mental health records.

This Authorization for Disclosure pertains to _____
Client name and date of birth

_____ _____
Client or legal guardian of client, above Date

Your signature below serves as an acknowledgement that you have read and been offered a copy of the Notice of Privacy Practices information form and Notice of Client Rights and Responsibilities provided by the practitioners at Interplay Counseling Services.

_____ _____
Signature of client or legal guardian Signature of therapist

_____ _____
Date signed Date signed