Heather K. Mazarakos MSW LCSW
HKM Psychotherapy Associates LLC
161 Cook Hill Rd Wallingford CT 06492

Authorization to Bill Insurance

I, _____

hereby give my consent for Heather K. Mazarakos MSW LCSW to bill my insurance carrier for the services rendered by the above-mentioned provider. In addition, I agree to pay Heather K. Mazarakos MSW LCSW any deductible or uncovered charge in accordance with my health care plan

Patient/Guardian Signature _____ Date: _____

Authorization to Release Medical Information to Insurance Carrier

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and /or treatment for HIV, sexually transmitted disease, psychiatric disorders or drug/alcohol use.

I, _____

hereby give my consent for Heather K. Mazarakos MSW LCSW to release medical and other relevant information to my insurance carrier as required to process medical billings.

Patient/Guardian Signature _____ Date: _____