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Authorization to Release Records for Scheduling & Billing Purposes

Client: ____ DOB: _________________

This form when completed and signed by you, authorizes Kathryn H. Leugers, Psy.D., LLC to release billing and scheduling information from your (or your child's) records to the responsibility party or parties that you designate. The responsible party/parties, will need to be given access to your (or your child's) www.therapyappointment.com login and password to be able to update contact information for billing purposes, receive encrypted e-mails from me with their credit or debit card receipts and service receipts to submit for out-of-network insurance benefits (if relevant). The responsibility party/parties WILL be able to see your (or your child's) therapy appointment times, current contact information inputted into the account, and diagnosis (if needed for insurance purposes). The responsible party/parties will not be able to access information regarding the content of the your (or your child's) psychological services, and this release does not entitle the responsible party/parties to that information.

I authorize Kathryn H. Leugers, Psy.D., LLC to release my login and password reset information on www.therapyappointment.com and any and all billing and scheduling information concerning my psychological services to:

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Cell phone: ____

E-mail: ____

_________________________________ **Client Signature (if 18 or older) / Date**

_________________________________ **Witness Signature / Date**

_________________________________ **Legal Guardian/Parent Signature / Date**

_________________________________ **Witness Signature / Date**

_________________________________ **Legal Guardian/Parent Signature / Date**

_________________________________ **Witness Signature / Date**