Kathryn Hoy Leugers, Psy.D., MBA
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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 a responsible financial party that you designate.

The responsible party will need to be given access to your www.therapyappointment.com login and password to be able to update contact and insurance information (if relevant), receive encrypted e-mails from me with their credit or debit card receipts and detailed service receipts to submit for out-of-network insurance benefits (if relevant).

The responsible financial party WILL be able to see your (or your child's) therapy appointment times, contact information inputted into the account, and your (or your child's) diagnosis (if needed for insurance purposes).

The responsible financial party WILL NOT be able to access information regarding the content of the your (or your child's) psychological services on the www.therapyappointment.com site, and this release does not entitle the responsible financial party to that information.

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

Name: _____

Address: _____

_____

Cell phone: _____

E-mail: _____

_____ _____
Client Signature (if 18 or older) Date

_____ _____
Legal Guardian/Parent Signature Date

_____ _____
Legal Guardian/Parent Signature Date

_____ _____
Witness Signature Date