Grace Counseling Services, PLLC

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Client's Name:_____

Date of Birth:_____Social Security Number:_____

I hereby give permission for, Grace Counseling Services, PLLC, to

Release/Obtain Information to/from **Blue Cross Blue Shield of Mississippi**

Information to be exchanged includes the following: Identifying Information, Diagnoses, Appointment Information
Other:_____

Authorization and Signature: I authorize the release of the information indicated above. I understand this authorization is voluntary, that the information to be disclosed is protected by law and the use/disclosure is to be made per my directions. I understand that to revoke this authorization I must provide a written request and the revocation will not apply to action or information that has already been released/obtained in response to this authorization. Any information obtained as a result of this release is confidential. I understand this release will expire one year from the date it is signed.

Signature:_____ Date:_____

Witness:_____ Date:_____