Sandalwood
Counseling LLC

Dr. Shannon Lilja DBH LPC LMHC CDP CADC-II

50 Basin Street, Suite 107, Astoria OR 97103
3800 SW Cedar Hills Blvd, Suite 152-D, Beaverton OR 97005

OR: 503.260.5118
Fax: 971.275.1081

Consent for the Release of Information / Request for the Release of Information

This authorization must be written, dated, and signed by the client or by a person authorized by law.

Client Name: _____ **Birthdate:** _____ **Last 4: SS #** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

I authorize Shannon Lilja/Sandalwood Counseling, LLC **Initial**: [ ] release information to [ ] obtain information from

_____	_____	_____	_____
Insurance Carrier	Address	Phone	Fax
_____	_____	_____	
Group #	ID #	Plan Name	
_____	_____	_____	
Insured's Name	Insured's Birthdate	Insured's Address	

Insured's Employer: _____

PURPOSE OF RELEASE **Initial**:

[ ] Insurance Coverage Information and Payment Processing.
Inquiring about coverage (including but not limited to estimation of benefits, deduction, copay information, etc)
Responding to requested information related to assessment, diagnosis, attendance, progress notes, treatment plans, etc

Please **Initial** each of the following to acknowledge that you understand and accept all terms of this financial agreement:

_____ I authorize my insurance company to be billed and I authorize the release of any information necessary to process claims. This may include patient and/or insured's information, including DOB, insurance policy number, address, phone, etc., patient biopsychosocial/psychological information including assessment and diagnosis of mental health or substance use disorders,** progress notes, treatment goals, attendance and/or discharge information.

_____ I agree to pay any co-payment, deductible or any fee for services not covered by my insurance company.

_____ I agree to provide copies of my insurance card and authorize Sandalwood Counseling to file a copy in my clinical chart. If I do not provide proof of insurance to Sandalwood Counseling, I understand that I will be responsible for paying for the services I receive.

This consent shall remain in effect until all claims submitted and service performed, are paid and/or satisfied... *unless designated otherwise here*: _____ Reason (describe: _____)

I understand information may be shared via phone, fax, electronic/written, or in person. The information shared will be the minimum level necessary to accomplish the purpose of this release. I understand I am not required to sign this release, and that the ability to access services will generally not be affected as a result of not signing. I realize refusal to sign may impact the coordination of services or treatment, and if related to insurance may impede coverage.

** I understand that my Records may be protected under state and federal confidentiality regulations (42CFR, Pt 2, RCW 71.05, 70.02, 71.34, 74.04, 13.50, 100(4)(b), and WAC 388-865-0436) and, if so, cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that Sandalwood Counseling cannot guarantee that the recipient of this information will not re-disclose my health information to another party. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it.

_____	_____	_____
Name	Signature	Date

SC: _____