INSURANCE RELEASE FORM

I. Individual

Individual:__________________________________ Date of Birth:______________________

Identification #:_____________________________ Group #:__________________________

II. Authorization and Purpose

I, request and authorize____ (insurance company)

and ____ (insurance company, if applicable) to

disclose my protected health information as described below:

Person/Organization:	Sharon J. Depowski, LCSW, CADC; Therapeutic Changes P.C.
Address:	311 East Dickens Avenue Northlake, IL 60164
Relationship:	Therapist
Purpose:	To obtain health plan benefit information and claim information.

III. Expiration and Revocation

I understand that I may revoke this authorization at any time by giving verbal notice to Sharon J. Depowski, LCSW, CADC. I understand that this authorization is voluntary.

Client:____ Date:____________

Client:____ Date:____________