INSURANCE RELEASE FORM

I. Individual

Individual:_____ Date of Birth:_____

Identification #:_____ Group #:_____

II. Authorization and Purpose

I, request and authorize_____ (insurance company) to disclose my protected health information as described below:

Person/Organization:	Sharon J. Depowski, LCSW, CADC; Therapeutic Changes P.C.
Address:	840 S Wisconsin Avenue, Villa Park, IL 60181
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:_____