Margaret Stearns, MSW, LICSW
5353 Gamble Drive, Suite #110
St. Louis Park, MN 55416
Phone: (763) 432-4070

Authorization For Release/Request of Medical Insurance Information

Client Name: _____

Date of Birth: _____

Medical Insurance: _____

Policy Number: _____ Group Number: _____

I authorize Margaret Stearns, LICSW to exchange information with:

_____

_____

_____

This information will be used for treatment planning and coordination of services. I understand that I am financially responsible for any unpaid medical claims.

I understand that I may revoke this consent at any time and that this revocation must be in writing. I also understand that a revocation will not apply to information that has already been released or disclosed. Unless otherwise revoked, this authorization will expire in one year from date signed.

_____

Signature of Client or Parent/Guardian Date