Peter J. Sanderson
License #**LF60210516**
LMFT, MHP, CMHS

South Sound Psychotherapy, LLC
2101 4th Ave E, Suite 200-Olympia, WA 98506
(360) 786-9499 peter@southsoundpsychotherapy.com
Fax (360) 786-0758

RELEASE OF INFORMATION TO INSURANCE COMPANY

Primary Insurance Company:_____ Policy #_____Group #_____

Secondary Insurance Company:_____ Policy #_____Group#_____

I hereby authorize Peter J. Sanderson, LMFT, to release to the above named insurance company or companies or its representatives, as well as South Sound Psychotherapy's billing agents, information pertaining to

_____(*print client name here*),

including the diagnosis and records of treatment or assessment rendered to me during the period of mental health care.

I also authorize and request the above-named company or companies to pay directly to Peter J. Sanderson, LMFT the amount due to me in my pending claim for mental health services.

_____ _____
Client name Date

_____
Client signature

_____ _____
Parent's name (if client is under 13) Date

_____
Parent's signature