Aletheia Therapeutics, PLLC
Michael Sibrava, NCC, LMHC
Billing Authorization

I (We) authorize Aletheia Therapeutics, PLLC, 901 Boren Ave, Suite 701, Seattle WA 98104 to release and disclose information from the clinical record of:

_____ _____
Name Date of Birth

to, and allow such information to be inspected and copied by: insurance companies, organizations, and/or agencies that may be concerned with the payment of services rendered.

Nature of information to be disclosed: all or any part of the medical records to the extent required to secure payment for services rendered

For the purposes of: payment of the mental health services rendered by Aletheia Therapeutics, PLLC or Michael Sibrava, NCC, LMHC

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Aletheia Therapeutics, that a revocation is not valid to the extent that Aletheia Therapeutics has acted in reliance on such authorization. This authorization is valid until revoked.

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences: Aletheia Therapeutics will not be able to bill or otherwise communicate on my behalf with insurance companies, organizations and/or agencies to seek payment for services rendered. Failure to sign this authorization will require me to pay the current full standard rate at the beginning of each appointment.

A copy of this release shall have the same force and effect as the original.

_____ _____
Client Signature Date

_____ _____
Representative Signature & Relationship Date

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.