



**David Hammer, M.A., M.F.T.**  
*Individual and Family Therapy*

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**AUTHORIZATION FOR RELEASE OF  
CONFIDENTIAL INFORMATION  
AND PAYMENT OF BENEFITS**

I, \_\_\_\_\_ request that David Hammer talk with or write to or send electronic claims to my health insurer or their representative to exchange information necessary to process my claim for counseling services for

\_\_\_\_\_. I understand that my health insurer reserves the right to review any and all information in the file. I further understand David Hammer has no control over what happens to my confidential information after it is received by the health insurer.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**I request that my health insurer or their representative pay David Hammer directly for psychological counseling services rendered, according to the terms of my insurance plan.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Bring this form to your next session or

fax to David Hammer at: (801) 365 - 7300

or email to: [counseling@davidhammer.com](mailto:counseling@davidhammer.com)