Kremer Psychology LLC

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RELEASE/EXCHANGE OF INFORMATION

Patient Name: _____ Patient Birthdate: _____

Insurance release

I hereby authorize Kremer Psychology, LLC to release to my insurance company any information necessary for purposes of approval of coverage and processing of claims for benefit purposes or for professional reasons only. This consent may be ended by me at any time, but ending the contract will not cancel any action that has already been taken as allowed by this form. It is understood that the duration of this consent will be no longer than necessary and only to carry out the purpose for which it was given.

★_____ _____

Signature of patient or authorized parent/guardian Date

I hereby authorize payment of medical benefits to Kremer Psychology, LLC for services rendered to me. **I fully understand that my insurance is billed by this office as a courtesy to me, and I am responsible for all charges incurred as a result of services rendered to me or my child.**

★_____ _____

Signature of patient or authorized parent/guardian Date

Physician Release/Exchange

I hereby authorize exchange of medical records to/from the individuals listed below (please include your referring physician). I request my records be released to/exchanged with the following:

1. Name: _____
Telephone Number: _____
Address: _____
_____

2. Name: _____
Telephone Number: _____
Address: _____
_____

★_____ _____

Signature of patient or authorized parent/guardian Date