SAVANNAH BEHAVIORAL Pediatrics

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RELEASE OF INFORMATION

Insurance release

I hereby authorize Savannah Behavioral Pediatrics, 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

_____ _____
Witness Date

I hereby authorize payment of medical benefits to Savannah Behavioral Pediatrics, 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 Date

_____ _____
Witness Date

Physician release

I hereby authorize release of my Savanah Behavioral Pediatrics records to any physician, medical personnel, or the specific individuals listed below (Please include your referring physician). I request my medical records be released to the following:

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

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

_____ _____ _____
Signature Date Signature of Witness