310 Eisenhower Drive • Building 5
Savannah, Georgia 31406
info@savannahbehavior.com
P: 912.436.6789 • F: 912.436.6835

______________________________ ________________

**Patient's Name** **Patient's Date of Birth**

**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.

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.

______________________________ ________________

Authorized Signer Date

______________________________ ________________

Name of Authorized Signer Relationship to Patient

**PHYSICIAN RELEASE**

I hereby authorize release of my Savannah Behavioral Pediatrics records to any physician, medical professional, or the specific individuals listed below. By signing this authorization form, I understand that my records contain information regarding my mental health. I give specific permission for this information to be released. I understand that my records are protected under State and Federal law and cannot be disclosed without my written consent unless otherwise provided for by law.

Name of Medical Provider: ____________________________________________________

Address of Medical Provider: __________________________________________________

Telephone Number of Provider: ___________________________________________________

I consent to the sharing of information with the above listed provider(s).

______________________________ ________________

Authorized Signer Date

______________________________ ________________

Name of Authorized Signer Relationship to Patient