Linda S. Klein, LPC, RPT/S
4251 Date Street
Colorado Springs, CO 80917
(71)538-3264

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize _____(therapist name) to release information from my records as requested by the

_____

Insurance Company/Companies

_____

Signature Date

ASSIGNMENT OF INSURANCE BENEFITS

I, _____ hereby irrevocably assign all medical benefits for services performed by _____(therapist name) to include major medical benefits to which I am entitled including private insurance, government sponsored programs and other health plan to _____ (therapist name).

I understand that I am financially responsible for all charges whether or not paid by insurance, and failure to meet this obligation may result in referral for collection.

I hereby authorized said assignee to release all information necessary to secure the payment of said benefits.

_____

Signature Date