Authorization to Release Billing Information

Patient: ____

Address:____

I hereby authorize Samantha Rosenblum to disclose and/or receive from

____

(name) (phone #)

information pertaining to my billing information rendered from now till termination.

Information shared will be billing information, including, dates of service, procedure codes, diagnosis and missed sessions.

This authorization is good until: Canceled

This authorization allows Samantha Rosenblum to discuss information described above and can be canceled at any time in writing by the patient.

Signature: ____ Date: __________

Ms. Rosenblum's signature: __________________________________ Date: __________

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