# Release of Information

Patient's Name: _____ Date of Birth: _____

Patient's Insurance ID #: _____

Insured's Name (if different that Patient): _____

Insured's Date of Birth: _____

Insurance Company: _____

Group #: _____ Plan #: _____

Patient's or Authorized Person's Signature to Release Information:
I hereby authorize the release of any medical information necessary to process claims for services rendered t me by Andrew M. Leeds, Ph.D.

_____
Signature Date

**Assignment of Benefits (Medicare Patients Only)**

Insured or Authorized Person's Signature to Assign Benefits:
I authorize payment of medical benefits to Andrew M. Leeds, Ph.D. for services rendered to me.

_____
Signature Date

Acknowledgement of Financial Responsibility:
I understand that in signing this authorization and assignment of benefits that I remain financially responsible. In the event that my insurance company or other third party payer does not make timely payment on my behalf, I agree to pay for such professional services.

_____
Signature Date

This permission is valid until revoked or for a period of one year from the date signed. Permission can be revoked by notifying Dr. Leeds in writing. I understand that after being released, this information may be re-disclosed by the person, agency, or corporation who has received it and may no longer be protected. I understand that I may refuse to sign this authorization.

Provider of Services: Andrew M. Leeds, Ph.D.
California Licensed Psychologist
PSY10471 MFCC13380

Client Received _____ Waived _____ a copy of this form.

Revised 01/13/2009