Julia M. White, LCSW
Licensed Clinical Social Worker

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Insurance Authorization for Claims Submission

I authorize the release of any medical or other information necessary to process my insurance claim for mental health benefits. I also request payment of insurance to the undersigned mental health provider.

_____

Client Printed Name Signature

_____

Parent or Legal Guardian Printed Name Signature
(If Primary Client is a Minor)

_____
Date

_____

Mental Health Provider Printed Name Signature

_____
Date

Please list all the information provided on your insurance card below (this information will be used for filing claims). If you prefer, I will make a copy of your insurance card.