Dr. Cynthia Edwards-Hawver, and Associates, LLC

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Authorization and Insurance Release of Information

By signing this document, I am allowing Dr. Cynthia Edwards-Hawver and Associates, LLC to release any medical information necessary in order to process my insurance claims. Dr. Cynthia Edwards-Hawver and Associates, LLC uses a confidential billing service that is HIPPA compliant (Mental Health Billing Services, LLC). I hereby authorize Dr. Edwards-Hawver and Associates, LLC to apply for benefits on my behalf for covered services rendered by their order. I understand that I will be personally responsible for any amount denied or any remaining amount owed for services partially covered by my third-party payer/insurer. I permit a copy of this authorization to be used in place of the original. By signing below, I acknowledge that I understand that Dr. Edwards-Hawver and Associates, LLC may need to release my diagnosis, dates of service, treatment goals, treatment notes, and other information in order to receive reimbursement.

Client's Printed Name _____

Policy Holder's Name _____

Policy Holder's Date of Birth _____

Insurance Company Name _____

Insurance Company ID (with prefix) _____

Insurance Phone Number _____

Client Signature _____

Date _____

Parent Signature if under 14 _____