



Release of Information Consent for Insurance Benefit Verification

Client Name:		DOB:	
Parent/Guardian Name:		Parent/Guardian Phone Number:	
Address:			

Are you aware of the associated costs for co-pays, coinsurance, and deductibles for your child’s insurance policy or policies?

- Yes
- No
- Unsure at this time

Please **do not** obtain information from any professionals or individuals regarding my family member.

OR:

Please obtain information from the listed professionals or individuals regarding my family member.

Check all that apply:

<input type="checkbox"/> Insurance Company MUST BE FILLED OUT	Name:
Phone:	Email:

<input type="checkbox"/> Primary Care Physician MUST BE FILLED OUT	Name:
Phone:	Email:

<input type="checkbox"/> Other	Details:
Phone:	Email:

CONSENT

I authorize A.P.P.L.E Consulting to obtain and/or release information regarding my child/myself regarding services provided to my child/myself verbally, in-person, via telephone or in written form, pertinent to services provided at A.P.P.L.E Consulting, as indicated below. I understand that any exchange will be handled with strict confidentiality. This consent shall expire one (1) year from the date of signature. I understand I may revoke my consent in writing at any time except to the extent that action has already been taken in reliance on it.

Parent/Guardian Signature _____

Date _____