Insurance Authorization Form

Patient: _____

Insurance Carrier: _____

Provider: Gordon Renwick, Psy.D.

By signing this form, I request payment of authorized benefits be made on my behalf to the provider listed above. I authorize any retainer of medical information regarding me and any information required to determine these benefits or the benefits for related services to be released to my insurance company.

Do you have any other insurance other than the one listed above that may pay for these services? Please initial next to the correct response YES____ NO____

Signed:_____

This form has been signed by:

____ Client

____Legal representative of minor

____Spouse or person financially responsible for client