Brandis Center, Inc.

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Release of Medical Information and Assignment of Benefits for Medical Billing

I authorize the release of medical information necessary for filing health insurance claims for me by Brandis Center, Inc.

I also authorize my insurance carrier(s) to make payment directly to Brandis Center, Inc.

I understand that it is my responsibility to update Brandis Center, Inc. immediately with any changes to my insurance policy, benefits, or carrier.

Insurance Information

Primary Insurance Company:		Policy ID:
Group #:	Policy Holder Name:	
Secondary Insurance Company:		Policy ID:
Group #:	Policy Holder Name:	
Relation to Patient:	D.O.B.: / /	

NOTE: This Release of Medical Information and Assignment of Benefits for Medical Billing expires one year after being signed.

Printed name of Parent/Legal Guardian Relationship Date

Signature of Parent/Legal Guardian Relationship Date