Sun Prairie Psychological Services
705 West Main Street, Suite 3
Sun Prairie, WI 53590

CONSENT TO RELEASE INFORMATION TO INSURANCE COMPANY

This authorization is effective for a period of one year. I hereby authorize Sun Prairie Psychological Services to release to (Insurance Company) _____ any information necessary to process the claim for (patient name) _____.

Name of Insured (if not patient) _____

Address: _____

_____

Insured's Phone #: _____

Insured's Date of Birth: _____

I hereby authorize payment for clinical services directly to Sun Prairie Psychological Services, 705 West Main Street, Sun Prairie, WI 53590 (608) 825-6663, Federal ID No. 39-1727747.

_____ Date: _____

Patient or Authorized Person's Signature