



**Client Authorization to Release Information
Billing of Services**

Client Name: _____ **D.O.B.:** _____

RH ID #: _____ **Date:** _____

I, _____, authorize Ravenhill Psychological Services to
(print full name)
release any medical or other information necessary to process claims of payment for services rendered. In addition, I authorize payment of medical benefits to Ravenhill Psychological Services for services rendered.

My signature indicates that I understand that it is my responsibility to inform Ravenhill Psychological Services of any changes in my insurance coverage. If my insurance coverage is cancelled or I have reached my maximum benefit for mental health service, I understand that Ravenhill will bill me directly for services rendered.

If applicable,

The client is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of the above named individual and I am authorized to consent to the aforementioned on behalf of this individual. _____
(Initial)

Signature: _____ **Date:** _____

Relationship to Client (if applicable): _____

Witness: _____ **Date:** _____