# BETH L. MURPHY, PSY.D.

## AUTHORIZATION TO BILL INSURANCE

I, ______________________________________________________, hereby give my consent for Beth Murphy, PsyD to bill my insurance company, ________________________________________, for services rendered to me by Beth Murphy, PsyD.

Signature: ____________________________________________ Date: _____________________

## ASSIGNMENT OF BENEFIT

I authorize my insurance company, ________________________________________, to pay medical benefits directly to Beth Murphy, PsyD.

Signature: ____________________________________________ Date: ____________________

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Beth Murphy, Psy.D. to release necessary medical information to my insurance company and/or to their designated managed Care Company, as is required by my insurance company to process my insurance claims.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Signature: ____________________________________________ Date: ______________________

SS#: ________________________________________________ DOB: ______________________

Witness Signature: _____________________________________Date: _______________________