SOF FORM

Kristen McClure MSW, LCSW

I authorize the use of this form on all of my insurance submissions ☐

I authorize release of information to my insurance company ☐

I understand that I am responsible for my bill ☐

I authorize my doctor to act as my agent in helping me obtain payment ☐

I authorize payment directly to my doctor ☐

I permit a copy of this authorization to be used in place as the original ☐

Signature

Date

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