• Certified Practitioner of Psychodrama & Group Psychotherapy
• Licensed Mental Health Counselor MH #2820
• National Certified Counselor

727.791.7200
deborahdayma.com

INSURANCE CONSENT FORM & RELEASE

NAME of INSURANCE COMPANY:

POLICY HOLDER:

Copay: Authorization: Number Sessions/Year

I request that payment of authorized benefits be made to **Deborah Day, M.A.**, for any services furnished by this provider. I authorize any holder of medical information about me to release to those persons or companies presenting a legitimate request for such information needed to determine these benefits or the benefits payable for related services. I authorize **Deborah Day, M.A.**, to act as my agent to help me obtain any required pre-certification as well as acting as my agent to obtain payment from my insurance company. I authorize my insurance company to give **Deborah Day, M.A.** any information they require to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Client's Signature Date

MEDICAL RECORDS RELEASE

I hereby authorize Deborah Day, M.A. to release any information in my chart to any medical practitioner, doctor, hospital, medical institution to whom I have been referred to assist in my care. Additionally, I authorize any request for medical information from my practitioner, doctor, hospital, or medical institution to assist in my care.

Client's Signature Date

2555 Enterprise Road • Suite 2 • Clearwater, Florida 33763