CAROL ELIAS, PH.D. **(909) 622-0148**
556 N. Diamond Bar Blvd., Ste. 103
Diamond Bar, CA. 91765

8608 Utica Ave., Ste. 213
Rancho Cucamonga, CA. 91730

AUTHORIZATION TO PAY PHYSICIAN
AUTHORIZATION TO RELEASE INFORMATION

I hereby assign any benefits payable and my rights and interest of said policy with _____ insurance company to be paid by check to and to be mailed directly to Carol Elias, Ph.D.

The medical expense benefits allowable and otherwise payable to me under my current policy, and payment toward the total charges for Professional Services are rendered. This payment will not exceed by indebtedness to the above mentioned assignee and I have agreed to pay in a current manner any balances of said Professional Services charges over and above this insurance payment.

This assignment will remain in effect until revoked by me, in writing. A photocopy is to be considered as valid as the original.

I further authorize the above named Mental Health Professional to release any information acquired in the course of my examination or treatment, as needed to secure payment.

Date: _____ Signature: _____

Printed Patient Name: _____