By signing this authorization, I allow South Charleston Pediatrics to disclose certain protected health information (PHI) to my insurance company in order to file a claim on my family's behalf. This authorization allows South Charleston Pediatrics to disclose protected health information which relates to my appointment with the office in order to bill my insurance on my behalf. The Date of Service, Level of Service, Reason for visit, Diagnosis, Amount, and any other related information the insurance my request may all be released to my insurance company in the sole capacity for billing purposes.

This authorization shall remain in effect the duration of the relationship between South Charleston Pediatrics and the patient.

The guardian may refuse to sign this authorization or end this agreement at anytime. Upon termination of this agreement, guardian must pay in full for the visit at the time of service. South Charleston Pediatrics will furnish any necessary billing information to the parent or guardian for them to seek financial repayment by the insurance company on their own.

I hereby give permission to South Charleston Pediatrics to bill my insurance on my behalf.

Date ________________

____
Parent/ Guardian Signature

____
Printed Name

____
Relationship

D.O.B. ______________

____
Child's Name