

Dr Cynthia Edwards-Hawver and Associates  
411 Davis Street  
Clarks Summit, PA 18411  
570 575 3765

**Authorization and Insurance Release of Information**

By signing this document, I am allowing Dr. Cynthia Edwards-Hawver and Associates, LLC to release any medical/psychological information necessary in order to process my insurance claims. Dr. Cynthia Edwards-Hawver and Associates, LLC uses a confidential, HIPPA compliant billing software program (Theranest).

I hereby authorize Dr. Edwards-Hawver and Associates, LLC to apply for benefits on my behalf for covered services rendered by their order. I understand that I will be personally responsible for any amount denied or any remaining amount owed for services partially covered by my third-party payer/insurer.

I permit a copy of this authorization to be used in place of the original. By signing below, I acknowledge I understand that Dr. Edwards-Hawver and Associates, LLC may need to release my diagnosis, dates of service, treatment goals, treatment notes, and other information in order to receive reimbursement through your insurance company. If you do not want this information shared with your insurance company, then you will be required to pay out of pocket for services.

Client's Printed Name \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Policy Holder's Phone Number \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_

Relationship to Policy Holder \_\_\_\_\_

Primary Insurance Provider \_\_\_\_\_ ID# \_\_\_\_\_

Insurance Phone Number \_\_\_\_\_ Group # \_\_\_\_\_

Copayment or Coinsurance due on Date of Service \$ \_\_\_\_\_

Secondary Insurance Provider \_\_\_\_\_ ID# \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_