

Allergy Associates of the Brazos Valley
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Permission to Discuss PHI between any/all employees of Allergy Associates, and my current Insurance Provider.

The undersigned hereby authorizes the release of and/or discussion of any private health information for myself and/or dependents with my current Insurance Provider. I authorize release of and/or discussion of eligibility, deductibles, co pays, limitations, and any other information needed concerning my coverage with this company.

Insurance Company: _____

Member/Provider Services Phone #: _____

Full name of Primary policy holder: _____

This person's Date of Birth: _____

Where is this person employed?: _____

Insurance ID#: _____

Insurance Group #: _____

Patient's Full Name: _____

Patient's Date of Birth: _____

How is patient related to the Primary policy holder?: _____

If patient has a different suffix or prefix on ID #,
please enter entire ID#: _____

(Authorized Signature of Subscriber)

(Date)

Call back phone number: _____