ALLERGY ASSOCIATES
of the Brazos Valley, P.A.
BARRY R. PAULL, M.D., F.A.A.P., M.A.A.A.A.I.
DIPLOMATE OF THE AMERICAN BOARD OF PEDIATRICS
DIPLOMATE OF THE AMERICAN BOARD OF
ALLERGY AND IMMUNOLOGY

Insurance Authorization

Permission to Discuss PHI between any/all employees of Allergy Associates, and my current Insurance Provider(s).

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, 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: _____
Primary policy holder's Date of Birth: _____
Primary policy holder's Employer: _____
Insurance ID#: _____
Insurance Group #: _____

Patient's Full Name: _____
Patient's Date of Birth: _____
How is this person related to the Primary policy holder?: _____
Does this person have a different Insurance ID# than the Primary policy holder?
Please enter that number here: _____

_____ _____
(Authorized Signature of Subscriber) (Date)

Phone: _____

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