

**THE SOZO CENTER
AUTHORIZATION FOR THE RELEASE OF CLIENT INFORMATION
ASSIGNMENT OF INSURANCE BENEFITS**

Please circle your response:

I **DO** **DO NOT** authorize **The SOZO Center** to release to my insurance company and its agents any information required to determine my eligibility for medical benefits in relation to services provided to me, my child and/or my family.

I **DO** **DO NOT** authorize direct payment to **The SOZO Center** of all insurance benefits payable to me for services rendered by **The SOZO Center**.

Both of the above authorizations (if applicable) will automatically expire one year following the last date on which services are rendered. However, I understand that I may withdraw my consent at any time. Should I choose to withdraw consent, I understand that **The SOZO Center** will no longer be able to bill to and/or share information with my insurance company following the date that my written withdrawal is received. In that case, I understand that I am responsible for any remaining bill and agree to pay it.

Client

Date

Legal Guardian (if client is a minor)

Date

Policyholder (if other than client or legal guardian)

Relationship to Client: _____

Witness

Date

11/05