

SIGNATURE ON FILE

- I authorize the use of this form on all my insurance submissions
- I authorize release of information to all my insurance companies
- I understand that I am responsible for my bill
- I authorize Jill Rubin, LCSW to act as my agent in helping me to obtain payment from my insurance companies
- I authorize direct payment to Jill Rubin, LCSW
- I permit a copy of this authorization to be used in place of the original

Printed Name _____

Signature _____ Date _____