

Eileen Moran, LCSW
1129 Northern Boulevard
Suite 404
Manhasset, NY 11030
Eileenlcsw@gmail.com
516-737-1241

Authorization to Release Information

I authorize Eileen Moran, LCSW
To release medical and other information as required for collection of benefits by insurance carriers and/or their agents or other third party sources of payment acquired in the course of my examination or treatment.

Assignment of Insurance Benefits

I authorize payment directly to:

Eileen Moran, LCSW

1129 Northern Boulevard
Suite 404
Manhasset, NY 11030
516-737-1241
Eileenlcsw@gmail.com

Insurance Company: _____

Member ID: _____

Group#: _____

Client Name

DOB

Client Signature

Date

Parent or Guardian Name

Date

Parent or Guardian Signature

Date