Valerie R. Wilson, Ph.D.
255 South 17th Street
Suite 1307
Philadelphia, PA 19103
Tel: 267-634-1719

RELEASE OF INFORMATION TO INSURANCE/MANAGED CARE COMPANY

I, ______________________________, give permission to Valerie R. Wilson, Ph.D. to release confidential information obtained during my treatment to my insurance company and/or its managed care company for the purpose of authorizations and/or reimbursement. I also authorize my insurance company and/or its managed care company to directly pay Valerie R. Wilson, Ph.D.

I understand that this authorization shall remain valid from the date of my signature below and ending on: ______________________.

I understand that I may revoke my authorization to release information from my records at any time by written or oral communication to Valerie R. Wilson, Ph.D., but not retroactive to the release of information already made in good faith.

I certify that this form has been fully explained to me and that I understand its contents.

______________________________________ __________
Signature of Client Date

______________________________________ __________
Signature of Parent or Guardian (if applicable) Date

______________________________________ __________
Valerie R. Wilson, Ph.D. Date