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Release of Information for Health Insurance Reimbursement

I, _____ (patient name), give permission to Synapse Association, Inc. and staff to and her current billing services provided by Physician Receivables Management L.L.C. and staff including Carolyn Groth, to release protected health information, only as requested by the insurance company and its representatives to my insurance company and its representatives. If I have requested that Synapse Association Inc. and staff prepare a “superbill” for the purpose of my own attempt to have my insurance company reimburse me, and I have submitted said “superbill”, I realize my insurance company may contact Synapse Association Inc. and staff with a request for additional information in order to process my claim. My signature below indicates Synapse Association Inc. and staff and Physician Receivables Management L.L.C. and staff have my permission to speak with my insurance company and its representatives about issues/questions related to my claim. I understand that there is no expiration date regarding this permission.

Patient Name (please print)

Patient Signature

Date