



Anderson Peak Performance
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**RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS,
REIMBURSEMENT POLICY, HIPPA ACKNOWLEDGEMENT FORM**

Authorization of Release of Information

I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government benefits to either myself or the party who accepts assignment.

Initial: _____

Authorization of Assignment

I authorize payment of medical benefits to **ANDERSON PEAK PERFORMANCE (DR. JEANNETTE M. ANDERSON)** for services rendered to me.

Initial: _____

HIPPA Acknowledgement (Notice of Privacy Practices)

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Initial: _____

NAME OF PATIENT: _____

SIGNATURE: _____

DATE OF BIRTH: _____

DATE: _____