Phone: (832) 252-9320
Email: admin@pedneurosleep.com

HOUSTON
PEDIATRIC NEUROLOGY & SLEEP
COMPASSIONATE. PATIENT CENTERED CARE.

Release of Billing Information Form

Houston Pediatric Neurology and Sleep, PLLC

Date: _____

Patient Information:
Name: _____
Address: _____
Contact Number: _____
Email: _____

Authorization:

I, _____, parent/guardian of _____, hereby authorize Houston Pediatric Neurology and Sleep, PLLC to release my billing information to the following individual(s)/organization(s):

Name: _____
Relationship to Customer: _____
Purpose of Receiving Billing Information: _____

Duration of Authorization: _____

This authorization shall remain in effect until otherwise revoked in writing by the customer.

Patient Name: _____

Parent/Guarantor Name: _____

Parent/Guarantor Signature: _____

Date: _____