Reliant
Pediatric Therapy Services
21630 Merchants Way, Katy, TX 77449
Phone: 832-230-1518 Fax: 281-741-7355
www.reliantpediatrictherapy.com

RE: Authorization Release Request

Patient Name: _____

Patient insurance ID: _____

Discharge date: _____

Therapy services: _____

To Whom It May Concern,

This is to inform you that my child's therapy service providers has changed from _____ to *RELIANT PEDIATRIC THERAPY SERVICES, PC*. To ensure continuation of therapy services, I hereby request that you release any prior authorization and issue a new one to *RELIANT PEDIATRIC THERAPY SERVICES, PC*. Thank you for your prompt attention to this request.

_____

Parent/Legal Guardian Signature

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RE: **Solicitud De Autorizacion**

Nombre de paciente: _____

Numero de Aseguransa: _____

Fecha de Descargo: _____

Servicios de Terapia: _____

A quien le corresponda,

Estoes para informarle de que los proveedores de servicios de terapia de mi hijo/a ancambiado de _____ a *RELIANT PEDIATRIC THERAPY SERVICES, PC*. Para garantizar la continuidad de los servicios de terapia, por el presentesolicitoquesuelte la autorizaciónprevia y emitirunonuevo para *RELIANT PEDIATRIC THERAPY SERVICES, PC.* Gracias porsuprontaatención a estepedido.

_____

Padre/Guardian Firma