

**DORIS M. DOMINGUEZ, MSW, LCSW  
LICENSED PSYCHOTHERAPIST**

**Authorization to Release Information**

I authorize Doris M. Dominguez, MSW, LCSW  
of  
9010 SW 137 Avenue  
Suite 236  
Miami, FL 33186

To release medical and other information as required for the collection of benefits by insurance carriers and/or their agents or other third party sources of payment acquired in the course of my examination or treatment.

**Assignment of Insurance Benefits**

I authorize payment directly to:

Doris M. Dominguez, MSW, LCSW  
9010 SW 137 Avenue  
Suite 236  
Miami, FL 33186

Insured or other authorized person's signature: I authorize payment of medical benefits to the undersigned provider of services.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date