RELEASE OF INFORMATION

“I hereby authorize any physician, health care practitioner or other medically related service to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurer.

I also authorize my health insurer to disclose to a hospital, provider or health care service plan, self-insurer, or an insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim.

If any coverage is under a Group Contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization, review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of the time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators.”

Patient’s Signature: ______________________ Date: __________________

Parent’s/Guardian’s Signature: _______________________ Date: __________________

Medicare Recipients:

“I request that payment of authorize Medicare benefits be made either to me or on my behalf to this office for any services furnished by that provider to me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.”

Patient’s Signature: _________________________ Date: ____________________

Parent’s/Guardian’s Signature: __________________________ Date: ________________

AUTHORIZATION TO PAY

“I Request payment of this claim and, if the payer accepts assignments, authorize payment direct to the physician of supplier for the service described.”

Patient’s Signature: ______________________________ Date: ______________________

Parent’s/Guardian’s Signature: ___________________________ Date: ____________________