Authorization for Release of Information
And Payment of Benefits

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I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby assign and authorize to the above stated office all medical and/or surgical benefits, including major medical benefits, to which I am entitled to under any insurance policy or policies, under self-insurance program, or any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to the above stated office by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Print patient name and date of birth: ______________________________

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Date of Birth

______________________________ ______________________
Person providing the authorization Date

______________________________ ______________________________
Relationship to patient if not patient Patient unable to sign due to