

Authorization for Release of Information

I authorize XXXXXXXX to release all medical information requested by my health insurance carrier, Medicare or any other third-party payers. I authorize XXXXXXXX to release all medical information to my referring physician and or primary care physician. I authorize XXXXXXXX to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to XXXXXXXXXX.

Signature

Patient/Legal Guardian: _____

Date: _____