INSURANCE AUTHORIZATION

Name:____ DOB:________________________

MRN:____ Appointment Date: ______________

I hereby authorize my insurance benefits to be paid directly to the above group, realizing I am responsible for payment of non-covered,non authorized services. I hereby authorize the release of information necessary to secure the payment of said benefits. I permit a copy of this to be used in place of the original.

Signature of patient: _________________________________ Date:__________________________