

**ASSIGNMENT OF INSURANCE BENEFITS**

**I hereby authorize direct payment of surgical/ medical benefits to Dr. \_\_\_\_\_, for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.**

**AUTHORIZATION TO RELEASE INFORMATION**

**I hereby authorize Dr. \_\_\_\_\_ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.**

**MEDICARE - MEDICAID**

**I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.**

**Patient (please print)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/ Guardian (please print)** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Provider's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Insurance authorization 1/01/01