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AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the above named professional corporation to release to my insurers and to other physicians full information, including copies of records and operative notes relative to any illness for which I receive services from the professional corporation. This authorization will continue in full force and effect unless cancelled by my request.

SIGNATURE OF INSURED

DATE

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment directly to the above mentioned for the benefits payable under terms of my policy. I understand that I am financially responsible for the charges not covered by this authorization.

SIGNATURE OF INSURED

DATE

A XEROX COPY OF THIS SIGNATURE SHALL BE VALID AS THE ORIGINAL.