Consent for Disclosure of Confidential Information

I, ________________________________ hereby consent to the disclosure of specified information listed in this document to my insurance carrier(s) and / or employer for the purpose of payment of medical bills for services dating from (*Specify Dates*) ________________________ to ________________________.

Permission to disclose the following is granted: (*Circle only what applies*)

Complete/Final Diagnosis. Test results/reports. Progress notes.

OP Reports. Discharge Summary.

This authorization is subject to revocation at any time upon advance receipt of written notice except to the extent that action has been taken in reliance thereon. In any case, this consent expires on the last date shown above.

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SIGNATURE DATE

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PERSON AUTHORIZED TO CONSENT FOR PATIENT RELATIONSHIP TO PATIENT

AUTHORIZATION OF ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION TO INSURANCE CARRIERS

I request that payment of insurance benefits be made directly for services rendered to me. I also understand that I am financially responsible for all charges not covered by my insurance carrier. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

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SIGNATURE DATE