AUTHORIZATION FOR RELEASE OF INFORMATION

AUTHORIZATION IS HEREBY GRANTED TO RELEASE TO (THE) INSURANCE COMPANY(S) ____

SUCH INFORMATION AS MAY BE NECESSARY FOR THE COMPLETION OF MY MEDICAL INSURANCE CLAIMS.

I UNDERSTAND THAT FULL PAYMENT MUST BE MADE PRIOR TO RELEASE OF ANY MEDICAL RECORDS FOR ANY PURPOSE OTHER THAN ABOVE.

DATE ________________ SIGNED____

PATIENT OR AUTHORIZED PERSON