AUTHORIZATION AND RELEASE

Patient name_____ DOB_____

RELEASE OF INFORMATION: I authorize the release of medical information to any Physician/Medical Facility involved in coordinating my care. I also authorize the release of any medical information necessary to process my insurance /Medicare/ Medicaid/Work Comp claim.

ASSIGNMENT: I hereby transfer and authorize payment to be directly made to Surgical Care P.C for any physician benefits payable by any third-party payer. I further agree that this assignment will not be withdrawn or voided until this account is paid in full. I understand that I am responsible for any charges not covered by my insurance. I also understand that payment in full is due upon receipt of statement. Unless payment arrangements have been made ahead of time with Surgical Care PC.

PATIENT'S INITIALS: ____

I authorize Surgical Care PC to discuss my medical information with the following:
Please list any family members or others who may be involved in coordinating your care or discussing your bill. If not listed on this form, we will not be able to discuss anything with them.

NAME	RELATIONSHIP	Contact Number

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify Surgical Care PC if you wish to alter the designations above.

PATIENT'S INITIALS: ____

PATIENT'S SIGNATURE: _____ Date: _____

GUARANTOR'S SIGNATURE (MINOR):_____