AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay for services not covered.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE: SIGN OR TYPE YOUR FULL NAME (By typing your name, you are agreeing to the above statements).

Patient or Legal Guardian: DATE: