AUTHORIZATION TO RELEASE INFORMATION

PLEASE BE ADVISED THIS OFFICE CANNOT LEGALLY BILL YOUR INSURANCE WITHOUT AN AUTHORIZATION TO RELEASE INFORMATION SIGNED BY THE PATIENT OR AUTHORIZED PERSON'S SIGNATURE.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND REQUEST PAYMENT OF MEDICAL BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS ASSIGNMENT OF BENEFITS.

SIGNED_____ DATE:_____

(Patient's or Authorized Person's Signature)

AUTHORIZATION TO PAY PHYSICIAN AND/OR GROUP

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO **LAKEWOOD ORTHOPAEDIC** OF THE MEDICAL EXPENSE BENEFITS OTHERWISE PAYABLE TO ME BUT NOT TO EXCEED MY INDEBTEDNESS TO SAID PHYSICIAN AND/OR GROUP ON THE ACCOUNT OF THE ENCLOSED CHARGES.

DATE:_____ SIGNED:_____

(Signature must be Employee and/or Policyholder)

NOTE: THE ASSIGNMENT OF BENEFITS WILL NOT BE MAILED WITH YOUR INSURANCE FORMS IF THE ACCOUNT IS PAID IN FULL AT THE TIME THE INSURANCE IS BILLED.