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**Insurance Authorization**

I authorize my physician to release any medical or other information needed to insure payment of insurance benefits on my behalf.

I understand that I will be responsible for any deductible or co-payments not paid by my insurance.

A copy of this authorization may be used in place of the original.

I assign the benefits payable for physician services to the physician furnishing the services.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_