Office Use: Chart # __________

Authorization Regarding Payment and Release of Medical Information

I hereby authorize and request the payment of services from Medicare, Medicaid, and/or other insurance plans or payers be made on my behalf to John A. Martin Primary Health Care Center. I hereby assign to John A. Martin Primary Health Care Center all payments for treatment services. I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid, and/or other insurance plans or payers.

I hereby authorize the release of medical information to Medicare, Medicaid, and/or insurance plans or other payers. I also authorize the release of medical information to other healthcare providers including, but not limited to, my primary care or family physician, consulting physicians or healthcare providers, hospitals, rehabilitation centers, or other healthcare providers or facilities. I permit a copy of this authorization to be used.

____

Printed Name of Patient

______________________________________ ____________________________

Signature of Patient Date

OR

____

Printed Name of Patient's Representative

______________________________________ ____________________________

Signature of Representative Date

____

Representative's Relationship to Patient

______________________________________ ____________________________

(Office Staff) Witness Signature Date