AUTHORIZATION, ASSIGNMENT & RELEASE FORM

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorization to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company, obligated to make payment to me or you based in whole or in part upon the charges made for your service.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you. I herby assign and transfer to you the cause of action that exists in my favor against any such company (the name(S) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and action in my name as your see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit, However, it is understood that until a reasonable effort has been made to collect the sums due from insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due. I personally owe and agree to pay to you.
4. In addition to the above, I herby waive the statute of limitations on collection and/or recovery in the State of________.
5. I further agree that this Authorization is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization of assignment will be in continual effort until revoked by both parties.

______________ ________________

Date Patient signature

RECORDS RELEASE

To______________________, I herby authorize you to release to _______________ any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from ______________ to__________________.

_______________ ___________________

Date Patient/Insured signature

_______________ ___________________

Date Staff Signature

RELEASE FROM CARE

I, ______________________ herby understand that Dr.___________ is releasing me from care, for my accident dated _____________, and that I have reached pre-accident or maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Patients Signature_________________ date_________ Staff Signature______________