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INSURANCE AUTHORIZATION

SIGNATURE ON FILE

____ I authorize use of this form on all my insurance submissions
____ I authorize release of information to all my insurance carriers.
____ I understand that I am responsible for my bill.
____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
____ I authorize payment directly to my doctor.
____ I permit a copy of this authorization to be used in place of the original.

Name____ **Group#**________________

Signature______________________________________ **Date**________________