



Release of Information / Insurance Assignment

Insurance Authorization & Assignment:

I hereby authorize examination and treatment by Augusta ENT, P.C. I authorize release of medical information to insurance carriers necessary to process claims and assign to the physician payments for medical services. I understand that it is my responsibility to remit payments for charges not covered by my insurance company. I understand that it is my responsibility to see that all claims, pre-certification, and authorizations are completed by my insurance company, since I am responsible for all professional services rendered to myself and/or dependent.

Signature: _____ **Date:** _____

Medicare Patients Only:

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration, its intermediaries, or carrier information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original and also request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: _____ **Date:** _____