SIGNATURE ON FILE

___ I authorize use of this form on all my insurance submissions.

___ I authorize release of pertinent information to all my insurance companies.

___ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

___ I authorize payment direct to my doctor.

___ I permit a copy of this authorization to be used in place of the original.

Print name: _____ SS#: _____

Signature: _____ Date:_____