OTOLARYNGOLOGY ASSOCIATES, PC
RELEASE OF INFORMATION

I, the undersigned, authorize Otolaryngology Associates, PC to speak with the persons listed below regarding my medical care. I understand that with my signature I am authorizing the release of written or oral communication by Otolaryngology Associates, PC to the listed persons and thereby release Otolaryngology Associates, PC and their staff from all legal responsibility that may arise from the act hereby authorized.

_____	_____	_____
Authorized Person	Relationship to Patient	Phone Number
_____	_____	_____
Authorized Person	Relationship to Patient	Phone Number

_____ _____

Signature of Patient / Responsible Party Date

ASSIGNMENT OF BENEFITS

I, _____(Please print your name) hereby authorize Otolaryngology Associates, PC to apply for benefits for covered services rendered by Otolaryngology Associates, PC, and to request that the payments from Medicare, Medicaid, Blue Cross/Blue Shield and/or _____ (other insurance company) be made directly to Otolaryngology Associates, PC if they choose to accept assignment, or to myself or to the party who accepts assignment.

I certify that the information I have reported with regards to my insurance is correct and further authorize the release of any necessary information, including medical information for this or any related claim to Medicare, Medicaid, Blue Cross/Blue Shield and/or _____ (other insurance as listed above).

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services provided to me by that physician/supplier. I authorize any holder of medical information about me to release to _____ (name of Medigap Carrier) any information needed to determine these benefits payable for related services.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at anytime in writing.

_____	_____	_____
Subscriber or Policy Holder Signature	Insurance I.D. Number	Date

RECEIPT OF PRIVACY PRACTICES WITH WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a written summary of Otolaryngology Associates, PC's Privacy Practices. I understand that a complete copy of the group's Notice of Privacy Practices is available, at no charge, upon request.

_____ _____

Signature of Patient/Responsible Party Date