

Jacksonville Hematology Oncology

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to Jacksonville Hematology Oncology all benefits, if any, otherwise payable to me for his/her services as described on the claim forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Jacksonville Hematology Oncology, will be credited to my account, in accordance with the above said assignment.

(Authorized Signature of Subscriber)

(Date)