Please Read the Following Carefully and Sign

Authorization for Release of Medical Information

I authorize *Sierra Vista Internal Medicine, PLLC* to release medical information requested by insurance companies or any public agency which may be assisting in payment of the below patient's medical care. I understand submission of a form or information does not establish a physician-patient relationship.

Assignment of Insurance Benefits

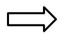
I authorize the assignment of benefits to be paid to *Sierra Vista Internal Medicine, PLLC*. I understand that I am financially responsible for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits when coverage is subject to co-ordination of benefits. In the event of default, I agree to pay all cost of collection, including attorney fees.

Referrals

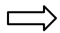
I understand that obtaining a referral is my responsibility. If I am seen without the necessary authorization and/or referral, I understand that I am liable for all charges.

This release of medical information and assignment of benefits is considered in force from the date of signing until revoked in writing.

By my signature I state that I understand and accept the conditions set above.

 ______________________________ ______________

Patient *or* Responsible Party's Signature Date

 ______________________________

Please print patient's name