

## **AUTHORIZATION FOR RELEASE OF INFORMATION**

**I hereby authorize Gary D. Salomon, M.D., to release Information requested by my insurance company or worker's compensation carrier. I also authorize Gary D. Salomon M.D., to release information to any hospital or physician I may be referred by this office.**

**Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**Relationship to Patient: \_\_\_\_\_**

## **ASSIGNMENTS OF BENEFITS**

**I hereby authorize assignment and payments directly to Gary D. Salomon, M.D., medical benefits due to me. I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCESSD OR THAT IS NOT COVERED BY MY INSURANCE.**

**(This does not apply to worker's compensation patient's)**

**Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**Relationship to Patient: \_\_\_\_\_**

**We request fees for office services and visits at the time the service is rendered**