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**SIGNATURE ON FILE**

- I authorize use of this form on **all** my insurance submissions
- I authorize release of information to all my **Insurance Companies**
- I understand that **I am responsible** for my bill
- 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

**Name:** \_\_\_\_\_ **Medicare#:** \_\_\_\_\_

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