

RELEASE OF INFORMATION AND BENEFITS STATEMENT FOR SIGNATURE

I authorize the release of medical information necessary to process my insurance claim. I understand these records may include psychological or psychiatric impairments, drug abuse, alcohol abuse, or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS) or test results for HIV.

I authorize payment of insurance benefits (basic, major medical, HMO, PPO, Medicare or Medicaid) to the undersigned physician or supplier for the services described on the attached claim.

I acknowledge that I am responsible for payment of fees assessed for appointments not kept or canceled with less than a 24-hour notice.

I have been informed that the privacy policy of Memorial Neurological Association as it pertains to my health information is posted in the waiting room and a copy is available to me upon request.

DATE SIGNED _____	SIGNATURE _____
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INSURANCE COMPANY NAME

INSURANCE CO. PHONE NUMBER

INSURED NAME/SUBSCRIBER

DATE OF BIRTH

SEX

SOCIAL SECURITY NUMBER

RELATIONSHIP TO PATIENT

EMPLOYER

I.D. #

GROUP #

IN EMERGENCY, NOTIFY (name and phone number of a person not previously listed on this form):

NAME _____ **PHONE ()** _____

PLEASE DO NOT WRITE BELOW THIS LINE