

Upper Cape Ear, Nose & Throat
Patient Information

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
AND INFORMATION RELEASE:

I, undersigned, authorize payment of medical benefits to Upper Cape Ear, Nose & Throat for any services furnished to me by the physician(s). I understand that I am financially responsible for any amount not covered by my contract. I also authorize Upper Cape Ear, Nose and Throat to release to my insurance company information concerning health care, including information about alcohol or drug use, or HIV status, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient's Signature (Parent/Guardian, if minor)

Date

Print name of *Patient* here

I have read the Privacy Policy for Upper Cape Ear, Nose & Throat, and any concerns have been addressed with me. I hereby give permission to release my medical information to the following relatives and/or friends:

Signature

Date