The Center For Skin Surgery

INSURANCE CONSENT AND MEDICAL RECORDS RELEASE FORM

We require your authorization to process your insurance
And release your medical record if necessary.
Carefully read, complete, and sign this form.

Patient Name: _____

Date of Birth: _____

I hereby authorize and direct my insurance carrier to pay The Center for Skin Surgery, Samuel E. Book, M.D., as appropriate, any benefits due under my insurance plan. I agree to pay any remaining balance or any expenses not covered under my insurance plan. I authorize the release of any medical information, relating to me or my family, necessary to process this claim. This authorization specifically includes information and records related to psychiatric care, alcohol and substance abuse evaluation and treatment, and the evaluation and treatment of HIV disease, if we have been evaluated or treated for any of these conditions. A copy of this release will be valid as an original; the release will be valid unless revoked in writing.

_____ _____

Patient Signature Date

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