PATIENT AUTHORIZATION

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: The Cleveland Gastroenterology associates and attending physicians are authorized to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment for my care.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Cleveland Gastroenterology Associates of benefits otherwise payable to me including major medical insurance and payment of surgical or medical, including major medical insurance benefits directly to attending physicians, but not to exceed regular charges for these services. I understand that I am financially responsible for charges not covered by this assignment.

MEDICARE – MEDICAID PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under titles XVII and XIX of the Social Security Act is correct. I authorize release of all records required to act on this request.

COLLECTION FEE: If your account is forwarded to a Collection Agency, you will be responsible for a collection fee of 40% of your account balance.

The above authorization is effective until revoked.

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Date **Witness** **Patient**

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Date **Witness** **Responsible Party** **Relationship**