SIGNATURE ON FILE
(ONE TIME AUTHORIZATION)

BRIAN LARSEN D.C.

TO: ____.
(DOCTOR/CLINIC NAME)

☑ I, ____ authorize the release of any
(PATIENT NAME)
medical or other information necessary to process my insurance claims.

☑ I authorize payment to be made direct to the above named doctor/clinic.

☑ I authorize the above named doctor/clinic to act as my agent in helping me obtain payment from my insurance companies.

☐ I request payment of government benefits either to myself or to the party who accepts assignment.

☐ I have signed the "ADVANCE NOTICE OF NON-COVERED MEDICARE SERVICES" and understand that I am personally responsible to the above named doctor/clinic for all non-covered services.

☑ I understand that I may revoke this authorization at any time in writing to the above named doctor/clinic.

☐ I permit a copy of this authorization to be used in place of the original.

Signature of Patient ______________________________ Date ______________

Witness to Patient's Signature ______________________________

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