LEPRE PHYSICAL THERAPY

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of the designated parties must be verified before the release of any information.

Name____________________________ Relationship__________________________

Name____________________________ Relationship__________________________

Name____________________________ Relationship__________________________

AUTHORIZATION SIGNATURE FORM

- I request that payment of insurance benefits for services rendered to me be paid directly to Lepre Physical Therapy.
- I authorize Medicare (if applicable) to send claims to my secondary insurance for crossover benefit payments.
- I authorize Lepre Physical Therapy to release medical information to my insurance carrier to determine benefits payable.
- I understand that I may revoke this authorization at any time with a renewed and dated signature.

My insurance is;

Primary____

Secondary____

_____________________________ _______________________________

Signature Date

I wish to **REVOKE** the above release for payment/release of medical information

_____________________________ _______________________________

Signature Date