AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my provider, The Urological Center/Antietam UroSurgical Center when he/she accepts assignment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize my provider, The Urological Center/Antietam UroSurgical Center to release any information necessary for my course of treatment.

______________________________	______________________
Signature of Patient	Date
______________________________	______________________
Printed Name of Patient	Date
______________________________	______________________
Witness	Date

Updated 11/25/2019