

**Release of Medical Information**

ASSIGNMENT OF BENEFITS: I voluntarily direct my Insurance company (or Attorney at Law) to pay Fischer, Schemmer, Silbiger, & Moraczewski, M.D., P.A., directly for charges for professional services rendered to me. THIS IS A DIRECT ASSIGNMENT OF BENEFITS UNDER THIS POLICY. I agree that I am responsible for any balance over and above insurance/attorney payment for these services. I authorize Fischer, Schemmer, Silbiger, & Moraczewski, M.D., P.A., to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I understand and agree that if collection efforts are necessary to obtain payment on this account, I will be responsible for all costs of such collection efforts, including reasonable attorney fees.

CONSENT TO TREAT: I voluntarily authorize Fischer, Schemmer, Silbiger, & Moraczewski, M.D., P.A. to administer examinations and care as deemed necessary for my condition.

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION TO RELEASE RECORDS: I voluntarily authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Printed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date