

Release of Medical Information & Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents. This signature will bind me as though the undersigned has personally signed the particular claim.

I _____ hereby authorize _____ to pay
Name of Insured, Parent, Guardian or Guarantor Name of Insurance Company

and hereby assign directly to Dr. JOANNA E. BETANCOURT all benefits, if any,

otherwise payable to me for his/her services as described on this form. I understand I

am financially responsible for all charges incurred whether or not paid by insurance. I

further acknowledge that any insurance benefits, when received by and paid to Dr.

JOANNA E. BETANCOURT will be credited to my account, in accordance with the

above assignment.

Authorized Signature

Date