Authorization to Release Med Pay Information and Two-Party Check

Patient Name :_____
Claim #:_____
Date of Loss:_____

To All Insurance Carriers and Agents:

I am currently being treated at Back to Life Chiropractic Center for injuries sustained as a result of an injury accident. Please be advised of the following:

1. I do hereby authorize you to disclose any and all information regarding Med Pay, to include amounts, calendar your, number of visits and any other pertinent information, as it pertains to my personal injury case.

2. I do hereby authorize you to disclose any and all information regarding liability insurance coverage as it pertains to my personal injury case.

3. I do hereby authorize you to notify Back to Life Chiropractic Center upon settlement and summation of my personal injury case.

4. I do hereby authorize you to prepare a twp-party check made out to Back to Life Chiropractic Center and me, upon summation and settlement of my personal injury case.

I am willing to a Photostat copy of this authorization be accepted with the same authority as the original. I understand that I (or a person authorized to act on my behalf) am entitled to receive a copy of this authorization form.

This authorization expires upon resolution of this claim.

_____ _____

Patient Signature (or Guardian if Minor) **Date**

_____ _____

Social Security Number **Date of Birth**