AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS AND CERTIFICATION OF ACCURATE INFORMATION

I hereby authorize Dr. Maria Szmidt and Dr. Izabela Witczak to release information which is normally required in the course of my treatment for the sole purpose of processing any insurance claim(s) submitted.

I hereby authorize my insurance company to send payment directly to Dr. Maria Szmidt and Dr. Izabela Witczak for any insurance benefits for services rendered. I understand that I am financially responsible for any unmet deductible, co-pays and for any charges of services not covered by my insurance, unless specifically prohibited by my insurance plan.

I have reviewed the preceding information and I certify that this information is correct. I further understand that I am responsible for any financial loss due to inaccurate or incomplete information provided by me.

Printed Name: ____

Signed: ____ Date: __________