MEMPHIS DERMATOLOGY CLINIC, P.A.

Patient Name ________________________________ Date of Birth ______________

Assignment of Benefits

I request that payment of authorized Medicare / Medicaid and/or other health insurance benefits be made on my behalf to ***Memphis Dermatology Clinic, P.A.*** for any services furnished to me by that provider. I authorize any holder of medical information about me be released to the Social Security Administration, Centers for Medicare and Medicaid Services (CMS) (its intermediaries or carrier) or my designated insurance company any information needed to determine these benefits or the benefits payable for related services.

I request authorized secondary/supplemental benefits be made on my behalf for any services furnished to me. I also authorize any holder of medical information to release any information needed to determine these benefits payable for related services.

______________________________ ______________________________

Signature of Patient (or Legal Representative) Date

==

Consent to Release Health Information

I authorize ***Memphis Dermatology Clinic, P.A.*** to release my medical records/health information to my insurance company and/or others for purposes of treatment, payment, healthcare operations and/or coordination of care.

______________________________ ______________________________

Signature of Patient (or Legal Representative) Date

I authorize any holder of health information/medical records about me to disclose this information to ***Memphis Dermatology Clinic, P.A.*** for purposes of treatment, payment, healthcare operations and/or coordination of care.

This agreement will remain in effect until revoked by me in writing to ***Memphis Dermatology Clinic, P.A.*** I agree that a photocopy of this authorization is to be considered a valid authorization.

______________________________ ______________________________

Signature of Patient (or Legal Representative) Date