AUTHORIZATION FOR RELEASE OF INFORMATION
AND PAYMENT OF BENEFITS

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDs confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby assign and authorize payment to Pediatric Associates/Cornerstone Medical Management of all medical/surgical and major medical benefits to which I am entitled to under any insurance policy or policies, under any self-insurance program, or under any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by my child or anyone on my behalf and I hereby accept such responsibility, including, but not limited to payment of those fees and charges not directly reimbursed to Pediatric Associates/Cornerstone Medical Management by any insurance policy, self-insurance plan or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

_____ _____

Person Providing Authorization Date

_____ _____

Relationship to Patient Date

Please list anyone other than the patient's parents who are authorized to bring this child into our office for medical treatment.

_____ _____

_____ _____

_____ _____

Name **Relationship**