

LIFETIME SIGNATURE AUTHORIZATION

I authorize the release of any medical information necessary to process this claim.

Subscriber's Signature

Date

I authorize payment of medical benefits to the physician who accepts assignment.

Subscriber's Signature

Date

FOR OFFICE USE ONLY

NAME:

DATE OF BIRTH:

DATE OF DISCHARGE:

HOSPITAL:

INSURANCE:

CIRC:

MALE OR FEMALE:

NORMAL OR C-SECTION: