Wrightstown Family Medicine, P.C.

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AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PHYSICIAN AND MAILED DIRECTLY TO THE ABOVE ADDRESS: I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for the services rendered for those services. I understand that if I voluntarily decide to continue treatment at this facility, with a Letter of Protection from my attorney, following the exhaustion of my medical benefits that the charges I incur will be paid to this facility prior to my case's settlement.

SIGNED (Insured Person): _____

DATE: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize the physician treating me to release any medical information acquired during the course of the treatment upon the request of my insurance carrier.

SIGNED (Patient or Parent, if minor): _____

DATE: _____

WORKMAN'S COMPENSATION PATIENTS ONLY (Please sign)
I hereby authorize the physician treating me to release any medical information acquired during the course of my treatment to my current employer.

SIGNED (employee): _____

DATE: _____