

NAME: _____ ACCT#: _____ DATE: _____

I herby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for any unpaid balance or non-covered services. This applies to services for which I have not paid in full.

I also authorize the physician to release any information, to include my medical records, as may be required in the processing of this claim

Signature (Parent, if patient is a minor)

RECORDS RELEASE: I herby authorize Hinsdale Hematology Associates to release any medical records or information upon my request.

Signature (Parent, if patient is a minor)

AUTHORIZATION FOR RELEASE OF INFORMATION

Date _____

Authorization Sent To:

Please Release to _____ M.D.

Hinsdale Hematology-Oncology Associates, Ltd.
908 N. Elm Street, Suite 210
Hinsdale, Illinois 60521
(630) 654-1790 Fax (630) 654-1845

Date _____

Information concerning the medical treatment of:

Name _____

___Records _____

Address _____

___Lab Reports _____

___Pathology Reports _____

Date of Birth _____

___Pathology Slides _____

Date _____ No. _____

Date _____ No. _____

___X-ray Reports _____

___X-ray Films _____

Signature _____

Other (specify)

Witness _____