Regional Rheumatology ASSOCIATES LLP

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Last Name, First	**Date of Birth**

Authorization To Release Information

I hereby authorize and direct Regional Rheumatology Associates to release to government agencies, insurance carriers, managed care companies, or others who are financially liable for my hospitalization and medical care and/or their authorized agents all information needed to substantiate payment for this medical care and to permit representatives thereof to examine and request copies of records to this case and treatment. I further authorize Regional Rheumatology Associates to release billing information to any provider involved in my care.

Guarantee of Payment

I understand that I am responsible for payment after insurance which includes all co-pay, coinsurance, deductible and non-covered services.

Assignment of Benefits

I hereby assign and transfer to Regional Rheumatology Associates sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover costs of the care and treatment rendered to myself or my dependent.

For Patients Entitled to Medicare Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians' services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

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Patient/Guarantor Signature Date