ARLINGTON CENTER FOR DERMATOLOGY
"Comprehensive Family Skin Care"
• Medical • Surgical • Cosmetic

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ASSIGNMENT OF INSURANCE BENEFITS AND MEDICAL INFORMATION RELEASE AUTHORIZATION

Insurance Benefits: I authorize the release of information necessary to process any claim. I certify the information I supply is true and correct to the best of my knowledge. I authorize payment of medical benefits to be made on my behalf to Arlington Center for Dermatology. I authorize photocopies of this form to be valid as the original.

Consent to treat: I authorize medical procedures to be performed on the patient named below at the direction of the physicians(s) of Arlington Center for Dermatology.

RELEASE OF MEDICAL INFORMATION

I authorize Arlington Center for Dermatology to release medical information (including chart notes, lab results, pathology results) to my primary care physician and/or specific healthcare providers requesting such information in regards to my healthcare.

I also authorize my physician to release confidential medical information, on my behalf to my insurance carriers and their employees in order to evaluate my insurance, reimbursement, and coverage for office visits and treatment and also may contact my employer and/or medical provider(s), to complete my request for payment.

I assert that I am a legal adult of 18 years of age or older and that if I am signing for a minor I am a legal guardian of the identified minor. I authorize Arlington Center for Dermatology to release medical information over the telephone to the following:

_____ Myself only

_____ Listed persons in my household:

List Names: _____

_____ Information may be left on voice mail at this number

PHONE # (_____)_____

Signature on file:
I acknowledge that I have read and agree to be bound by the terms and office policies stated above in areas of the Assignment of Insurance Benefits and Medical Information Release Authorization. The duration of this authorization is indefinite or until it is revoked in writing.

PATIENT NAME: _____ **DATE:** _____

Signature: _____
(Patient or legal representative)