AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE WOODLAND PROFESSIONAL ASSOCIATES, PLLC, AND THE INDIVIDUALS INCLUDED IN THIS PROFESSIONAL PARTNERSHIP, TO RELEASE MEDICAL INFORMATION NECESSARY TO BILL FOR AND SUBSTANTIATE:

_____
Name of Patient

PRIMARY INSURANCE CO._____

SUBSCRIBER_____EFF_____
(employee's name)
SUBSCRIBER'S ADDRESS, IF DIFFERENT FROM PATIENT_____

_____

SUBSCRIBER'S EMPLOYER_____

CERTIFICATE/ID NO._____GROUP NO._____

SECONDARY INSUR. PLAN, IF AVAILABLE_____

SUBSCRIBER NAME_____

SUBSCRIBER'S ADDRESS, IF DIFFERENT FROM PATIENT_____

_____

CERTIFICATE /ID NO._____GROUP NO._____

I understand I am responsible for verifying insurance benefits and obtaining necessary prior authorizations and referrals. I also understand that I am responsible for all fees, regardless of my insurance coverage. I have read the above statements and understand them.

I FURTHER UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME SHOULD I DESIRE BY NOTIFYING THE OFFICE IN WRITING.

_____ _____
Date Signature of Patient or
Legal Representative