

AUTHORIZATION & RELEASE

Patient Authorization & Release:

I _____ certify that the Patient Information provided is true and correct to the best of my knowledge. I also understand as courtesy Dr. M. Mitchell Silver will file my insurance and that he accepts assignment for services rendered. I acknowledge however, that I am responsible for any co-payment, co-insurance, and/or deductible and ultimately responsible for payment for these services rendered by Dr. Silver.

I understand that providing incorrect and/or outdated information can hinder payment. I pledge to notify Dr. Silver's staff of changes as they occur.
(Example: Address, Phone #, Employer, Insurance, Martial Status)

I authorize the release of any information concerning my (my child's) treatment for the purpose of evaluating and administering claims for insurance benefits. This includes but is not limited to providing copy of medical records and or patient information provided to Dr. M. Mitchell Silver.

Patient Name (Print)

Patient Name/Legal Guardian (Signature)

Date

Witness (Dr. Silver's Staff)

Date