

AUTHORIZATION FOR RELEASE OF PRIVATE HEALTHCARE INFORMATION

By signing this document, I agree to release of medical information and any other private healthcare information between Dr. Theodore H. Bowlus, D.P.M., Inc. and any physician or provider of medical services and/or medical equipment deemed necessary by Dr. Bowlus to assist in the treatment of my medical condition. I also authorize release of my private healthcare information to my medical insurance company or companies and any other business affiliates of Dr. Bowlus, D.P.M., Inc., as necessary, to facilitate the filing and payment of medical claims filed on my behalf.

\_\_\_\_\_  
Patient's Signature (or responsible party if a minor)

\_\_\_\_\_  
Date

ASSIGNMENT OF INSURANCE BENEFIT

By signing this document, I authorize my insurance company to pay an applicable insurance benefits directly to Dr. Theodore H. Bowlus, D.P.M., Inc., realizing that I am ultimately responsible for any charges not covered by my insurance plan or plans, as required by my contract with my insurance company, or as specifically agreed between me and Dr. Theodore H. Bowlus, D.P.M., Inc.

\_\_\_\_\_  
Patient's Signature (or responsible party if a minor)

\_\_\_\_\_  
Date

\*\*\*MEDICARE PATIENTS ONLY\*\*\*

I request that payment of authorized Medicare Benefits be made on my behalf to the physician, Dr. Theodore H. Bowlus, D.P.M., Inc., for any services furnished to me by Dr. Bowlus. I authorize release to the Health Care Financing Administration and its agents any medical information about me that is needed to determine the payments for my medical treatment and any related services.

\_\_\_\_\_  
MEDICARE BENEFICIARY'S NAME

\_\_\_\_\_  
DATE