LIFETIME AUTHORIZATION

Insurance Assignment and Authorization to Release Medical Information

RELEASE OF INFORMATION: I, the below named patient, do hereby authorize any physician examining and/or treating me to any third party payor (such as insurance company or government agencies, example: Blue Shield or Medicare) any medical condition – including HIV status/test results, psychiatric condition, alcohol or drug related condition, and records concerning diagnosis and treatment when requested in writing by such third party for its use in connection with determining a claim for payment, for such treatment and/or diagnosis.

PHYSICIAN INSURANCE AGREEMENT: I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services, when under contract by that insurance company.

MEDICARE/MEDICAID: The patient's certification authorization to release information and payment request, I certify that the information given by me applying for payment under TitleXVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release Social Security Administration/Division of Human Services or its intermediaries or their carriers, any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurances pertaining to treatment shall be assigned to the physician treating me.

I PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENT TO BE USED IN PLACE OF THE ORIGINAL THAT IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fee paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and other pay a percentage of the charge.

I understand it is my responsibility to pay any deductible amount, and any co-insurance (co-payment) at the time services are rendered. Any other balance not paid by my insurance or third party within a reasonable period is not to exceed 60 days. If this account is assigned to an attorney for collections, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

PATIENT'S SIGNATURE____DATE______________________

SUBSCRIBER (if different from patient)____

Original Signature on File at Physician's Office

MEDIGAP SECONDARY

________________________________ ____

Name of Beneficiary Health Insurance Company

I request that payment of authorization Medigap)secondary insurance) benefits be made on my behalf to Gainesville Internal Medicine Physicians for any services furnished me by Steven C. Jones, MD; William A. Rios, MD; Ioleen Alexis Dell, MD; John J. Burton, MD; Drue M. Ferrante, MD; Christopher R. Guy, MD; Robert C. Slaton, MD; Deborah J. Morris, MD; Manuel F. Diaz, MD; Priscilla Givens, MD. I authorize any holder of medical information about me to release to the above named insurance company any medical information- incuding HIV diagnosis or related conditions, psychiatric conditions, alcohol or drug related conditions needed, and requested in writing, to determine benefits or the benefits payable for related services.

Subscriber's Signature:_______________________________________Date:_________________________