

EXTENDED AUTHORIZATION AND CONSENT

BILLING OFFICE:

ALLERGY & ASTHMA ASSOCIATES – SOUTH
33 COHASSET AVENUE
BUZZARDS BAY, MA 02532
TEL: 508-759-7555

I request that payments of medical benefits be made directly to the above named provider on any unpaid bills for services rendered. I further authorize the release of any medical information necessary to process this or related claims. I permit a copy of this authorization to be used in place of the original.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

REFERRAL AUTHORIZATION

Please sign this if your insurance requires a referral from a primary care physician.

We are always happy to submit a claim to insurances requiring referrals for services rendered. However, in most cases, these insurances do not cover any service which is not approved, arranged or provided by your primary care physician. (Please consult your member handbook for a list of services which do not require a referral from your primary care physician.)

Your signature below indicates that if you receive specialty services without the consent of your primary care physician, you will assume financial responsibility for such services.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Occasionally, one of our physicians requires a copy of **past** X-rays, MRI/CT scans, ER reports, etc., from either your primary care physician or hospital where testing/treatment was done. Your signature below authorizes the release of such medical records, including any laboratory reports, diagnostic testing, X-rays, etc., to Allergy & Asthma – South. **At no time** will this information be requested without your prior knowledge.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____
