



110 Acadia Drive, Raceland, LA 70394 ■ Phone: (985)537-8687 ■ Fax: (985)537-8976

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Children's Clinic of Raceland or any holder of medical information about me to release to the Health Care Financing Administration and its agents (Medicare) or Insurance Companies or Third Parties, information needed to determine these benefits or the benefits payable for related services.

ASSIGNMENT OF BENEFITS

I request that authorized Medicare or Insurance payments of medical benefits be made to the Children's Clinic of Raceland (to be used only if necessary to file claims).

GUARANTOR RESPONSIBILITY

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by the Children's Clinic of Raceland and if this assignment is rejected, modified, or not paid within a reasonable time since it has been filed, it will be my responsibility to pay any unpaid charges in full. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charges assessed by the collection service and legal counsel.

This authorization and assignment may be revoked by me at any time by a written notice.

I agree that a photocopy of this form may be used in lieu of the original

Signature (Parent/Guardian Insured)

Date