

**RELEASE OF INSURANCE INFORMATION**

I hereby authorize Sports Medicine and Orthopedic Center, S.C. to furnish the insurance companies listed below, all information which said companies may request concerning my present illness or injury, or any other insurance company that is associated with my care.

I hereby assign to Sports Medicine and Orthopedic Center, S.C., all sums payable to be from the amount of money to which I am entitled for medical and/or surgical expenses, but not to exceed the charges for those services. **I understand that I am financially responsible for those charges not paid by my insurance.**

I agree that a photocopy of this, my original authorization, shall be considered equally authentic.

NAME OF INSURANCE COMPANY: PRIMARY \_\_\_\_\_

SECONDARY \_\_\_\_\_

DATE \_\_\_\_\_

SIGNED \_\_\_\_\_

**RELEASE OF MEDICAL INFORMATION**

In addition, you are hereby authorized to give to \_\_\_\_\_

Address: \_\_\_\_\_

or any representative thereof, any and all *information* which may be requested regarding my physical condition and treatment rendered, and to allow them, or any physician appointed by them, to examine any x-ray picture taken of me, or records which you may have regarding my condition or treatment.

Signed \_\_\_\_\_ Witness \_\_\_\_\_