Georgia Infectious Diseases, P.C.
5673 Peachtree Dunwoody Road, Suite 600
Atlanta, Georgia 30342

Authorization For Release of Information and Payment of Benefits

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any healthcare related utilization review or qualifies assurance activities.

I hereby assign and authorize payment to Georgia Infectious Diseases, P.C. of all medical and surgical Benefits, including major medical benefits, to which I am entitled to under any insurance policy or policies, under any self-insured program or under any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including but not limited to payment of those fees and charges not directly reimbursed to Georgia Infectious Diseases, P.C. by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain valid during my care at Georgia Infectious Diseases, P.C... A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Patient Signature _____ Date _____/_____/_____

Signature of Parent or Legal Guardian _____ Date _____/_____/_____

Patient Unable to Sign Due to _____

Witness _____ Date _____/_____/_____