# Mid Michigan Dermatology
## Patient Authorization, Assignment, and Agreement for Hospital, Physician, and/or Surgeon Services Performed

_____
**Patient Name** (Please Print)

Authorization

I hereby authorize Mid Michigan Dermatology, it's Owner, President or designees, physician and/or surgeon to release to my insurance company and/or third-party payor(s) and/or external review agency(s) such information contained in my patient records as is necessary for the payment of insurance benefits without regard to any limitation placed on dates, history of illness or diagnosis and therapeutic information, including any testing and/or treatment for AIDS, AIDS-Related Complex (ARC) or HIV infection ( MI 1989 Public Act 174). This authorization expires upon full payment of insurance benefits unless previously revoked, and may be revoked at any time except to the extent that action has been taken by the hospital, physician, surgeon in reliance thereon. I certify information furnished for claims to be true and correct.

Assignment

I assign to Mid Michigan Dermatology, it's Owner, President or designees, physicians and/or surgeons all rights to benefits, insurance proceeds, settlement payments, or judgements I may be entitled to, for services rendered and authorize them to submit a claim for payment on my behalf to my insurance company.

Agreement

I understand that the health insurance plan in which I am enrolled may require prior authorization or approval for coverage of treatment. In the case that coverage for the outpatient services has been requested and subsequently denied by the insurance company, I understand that if I elect to have these services performed, I will be liable for all of the respective charges that are incurred.

_____ _____

Signature of Patient Date Signature of Witness Date

_____

Signature Parent or Guardian Date