MEDICAL INFORMATION RELEASE
For
Moving Vehicle Accident

PATIENT NAME: _____

I hereby authorize Devon Family Practice, LLP to release all medical information/records pertaining to my treatment as a result of a moving vehicle accident claim to the insurance company, its intermediaries or carriers, and/or attorneys acting on my behalf, said authorization to continue in effect until cancelled in writing by me.

I understand that, as such services were rendered on behalf of me and/or my legal dependent(s); I am financially responsible for all incurred charges should the claims be denied by the aforementioned third parties. It is further understood that Devon Family Practice, LLP will accept assignment (the approved charge determined by the insurance carrier) as payment in full, and that I will not be held responsible for the difference between the billed amount and the approved charge.

SIGNATURE _____ DATE_____

Please complete the following; we need all information filled in before we can submit a claim.

PATIENT NAME: _____ DATE OF ACCIDENT_____

ACCIDENT CLAIM NUMBER: _____

AUTO POLICY NUMBER: _____

NAME OF YOUR AUTOMOBILE INUSRANCE COMPANY_____

BILLING ADDRESS WHERE WE MAIL

THE CLAIM: _____

Street *City* *State* *Zip*

ADJUSTER'S NAME: _____

TELEPHONE NUMBER: _____

Please return to the Bookkeeping Department. Thank you.