Elyse Rubenstein, M.D., F.A.C.R.
A Professional Corporation

Authorization to Release Information

I hereby authorize Elyse Rubenstein, MD A Professional Corporation to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company.

Signature_____Date_____

Assignment of Insurance Benefits

I hereby authorize direct payment of insurance benefits directly to Elyse Rubenstein, MD A Professional Corporation for any services rendered under her and her supervision. I understand that I am financially responsible for any balance not covered by my insurance plan.

Signature_____Date_____

Medicare/Medicaid

I request that payment of authorized Medicare benefits be made on my behalf. I authorize release of all information to the Centers for Medicare and Medicaid Services on request. A photocopy of these assignments shall be valid as the original.

Signature_____Date_____