AUTHORIZATION, ASSIGNMENT & RELEASE FORM

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you. I herby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute an action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance company's proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.

4. In addition to the above, I herby waive the stature of limitations on collection and /or recovery in this State of Florida.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization for Assignment will be in continual effect until revoked by both parties.

____ ____________

Patient/Insured Signature **Date**

ASSIGNMENT OF AUTOMOBILE INSURANCE BENEFITS

I hereby assign and transfer to The Bolick Clinic, Inc. any and all causes of action that exist in my favor against any automobile insurance company for personal injury protection or medical payments coverage benefits.

Signature: _____________________________ **Date:** ______________ Witness: _________________

RECORDS RELEASE

To ____________________________, I hereby authorize you to release to **The Bolick Clinic** (fax 407-629-5343) any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from _________________ to _________________. □ **Complete Records** □ **Recent Progress Notes**

□X-ray Reports **□X-ray Films** **□Diagnostic Imaging Reports** **□Lab Reports** □ **Other** ___________________

__________________ __________________________

Date: **Patient/Insured Signature**