

## **SIGNATURE RELEASE STATEMENT**

**YOUR SIGNATURE IS NECESSARY FOR US TO:**

- 1. PROCESS ALL INSURANCE CLAIMS**
- 2. INSURE PAYMENT FOR SERVICES RENDERED**
- 3. RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES**
- 4. RELEASE INFORMATION TO OTHER MEDICAL/DENTAL PROVIDERS, WHEN NECESSARY FOR YOUR TREATMENT**

I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I assign all medical and surgical benefits to which I am entitled, to Dr. Randy Fong. This assignment will remain in effect until revoked by me *in writing*. A photocopy of this assignment is to be considered as valid as the original.

Patient \_\_\_\_\_ Responsible Party \_\_\_\_\_  
(parent, if minor)

Witness \_\_\_\_\_ Date \_\_\_\_\_