LIFETIME AUTHORIZATION FOR INSURANCE/MEDICARE

I request that payment of authorized Insurance/Medicare benefits be made on my behalf for services furnished me by Dr. Stanley Hallock.

I authorize any holder of medical or other information about me to release to the health care financing administration and/or it's agents information needed to determine these benefits for related services.

I request that payment of authorized Insurance/Medicare benefits be made on my behalf to Dr. Stanley Hallock for any services for me by a physician or supplier. I authorize any holder of medical information about me to release to any of my insurance companies any information needed to determine these benefits payable for related services.

I hereby authorize payment directly to Dr. Stanley Hallock of benefits otherwise payable to me. I understand and agree that any unpaid balances not covered by my medical policy will be payable by me. This includes coverage denied as a result of preexisting conditions.

I permit a copy of this authorization to be used in place of the original. Regulations pertaining to Medicare assignments of benefits apply.

I further authorize Dr. Stanley Hallock to fax the results of my evaluations to my referring physicians if appropriate.

SIGNATURE____

PARENT/GUARDIAN____

DATE______________________

AUTHORIZATION TO RELEASE INFORMATION

Without your express written permission, Dr. Stanley Hallock cannot discuss your treatment or billing information with anyone but you, the patient. If treatment or billing information is to be discussed with a SPOUSE, FAMILY MEMBER, CARE GIVER, GUARDIAN please list their names below. If you are here by yourself today, you may skip this portion of the form today.

NAMES:____

SIGNATURE____

DATE______________________