Patient Name: _____Date _____

In order for us to submit a claim for services covered under your policy, we must have your authorization to release medical information to your insurance carrier. Please read and sign the following statement:

I authorize Dr. Katheryne W. Glantz and whomever she may designate, to furnish my insurance company or Medicare with all necessary information regarding my present illness or injury. I also authorize payment of medical benefits to Dr. Katheryne W. Glantz and whomever she may designate for medical supplies or services provided with the understanding that any overpayment will be reimbursed to me promptly. A photostactic copy of this authorization be considered as effective and valid as the original. I authorize Dr. Katheryne W. Glantz to treat the above-named patient. I understand that honest and complete answers to each question stated on the Podiatric History Form are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any questions on the form, I should ask the doctor or medical staff for assistance.

Patient Signature _____ Date _____

Signature of Parent/Guardian _____Date _____