Patient Name:________________________________

Date:______________________________

File In Chart #_____________________

Brainerd Medical Center, P.A.

2024 South Sixth Street
Brainerd, MN 56401-5504

AUTHORIZATION FOR RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

RECORD RELEASE: I authorize Brainerd Medical Center, P.A., to release medical information about me to my insurance carriers, the Social Security Administration or its intermediaries/carriers, Centers for Medicare & Medicaid Services (CMS) and its agents for purposes of payment, and to referring physicians and other providers involved in my care.

ASSIGNMENTS OF BENEFITS: I authorize payment of Medical/Medicare benefits to Brainerd Medical Center, P.A., for any services furnished by this clinic to me. I understand I am financially responsible for charges not covered by Medicare and/or my insurance carriers.

This authorization also covers charges generated by Brainerd Medical Center physicians for services received at St. Joseph's Medical Center or other medical facilities.

I permit a copy of this authorization to be used in place of the original.

DATE__________________

SIGNATURE_____________________________

(Relationship if patient is a minor:_______________________________)