

**AUTHORIZATION, ASSIGNMENT & RELEASE FORM**

**AUTHORIZATION AND ASSIGNMENT**

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 you incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the 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 changes made for your services, refuses to make such payment upon demand by you. I hereby 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 and take 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 the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Virginia.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effort until revoked by both parties.

\_\_\_\_\_  
Date Patient/Insured Signature

**RECORDS RELEASE**

To \_\_\_\_\_, I hereby authorize you to release to \_\_\_\_\_ any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from \_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_\_  
Date Patient/Insured Signature Date Staff Signature

**RELEASE FROM CARE**

I, \_\_\_\_\_ hereby understand that Dr. Brown is releasing me from care, for my accident dated \_\_\_\_\_, and that I have reached [ ] pre-accident status or [ ] maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_ Staff Signature \_\_\_\_\_