

Affiliated Psychological & Medical Consultants, L.L.C.

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**MEDICAL RELEASE OF INFORMATION
AND
ASSIGNMENT OF BENEFITS**

PATIENT'S NAME : _____

Please sign **BOTH** of the following Authorization Statements below:

I authorize the release of medical records or other information necessary to process this claim.

SIGNED _____
(Patient, insured or authorized person's signature)

I authorize payment of benefits to the Doctor for services rendered.

SIGNED _____
(Patient, insured or authorized person's signature)

Thank you!