

Patient Label

Comments:

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient

Patient or Personal Representative Signature

Date

I authorize Holzer Clinic the option of directing payment to me.

I authorize payment of medical benefits to Holzer Clinic.

I certify that information given to apply for payment under the Social Security Act or my insurance is correct.

I acknowledge that I have received a copy of Holzer Clinic's Notice of Privacy Practices.

Acknowledgement and Authorization

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