HEIGHTS DERMATOLOGY
& AESTHETIC CENTER
"Taking Your Skin to Greater Heights"
Dr. Alpesh Desai • Dr. Tejas Desai

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

Medical Record Number: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

Private Insurance Authorization for Assignment of Benefits and Information Release:
I, undersigned, authorize payment of medical benefits to Heights Dermatology & Aesthetic Center for any services furnished to me. I understand I am financially responsible for any amount not covered by my insurance.

Date: _____ Signed: _____
Insured or Responsible Party

Medicare Patients Only:
I request the payment of authorized Medicare benefits be made on my behalf to Heights Dermatology & Aesthetic Center for any services furnished me by the physician. I authorize any holder of medical information about me to release to The Health Care Financing Administration and its agents, by mail or fax; any information needed to determine these benefits or benefits payable for related services.

Date: _____ Signed: _____
Insured or Responsible Party

MEDICAL RECORDS RELEASE

Medical Records Release:
I authorize you to release to my insurance company and my consulting physician, by mail, fax or secure internet, information concerning health care, advice, treatment, or supplies provided to me. This information will be used for treatment, payment and operations. Refer to privacy notice.

Date: _____ Signed: _____

Parent or legal guardian signature: _____
Required for minors through age 17

Relationship to patient: _____