RELEASE OF MEDICAL INFORMATION

I authorize Bay Area Family Physicians, P.C. to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, or any other insurance carrier any information needed to **process any medical claim I may incur.** I request payment of medical insurance benefits directly to Bay Area Family Physicians, P.C. for services which I receive.

I understand that **if I have no insurance coverage, or if my insurance does not cover a portion of the charges, I am responsible for payment.** I also understand that **payment is expected at the time of services.**

Insurance Company

Signature Date