PLEASE WAIT TO SIGN THIS FORM WHEN YOU ARRIVE FOR YOUR APPOINTMENT

TO: ______________________________ **DATE:** ___________________

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RE: ______________________________

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******* PATIENT OR AUTHORIZED PERSONS SIGNATURE PLEASE *******

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION REQUIRED BY MY INSURANCE CARRIER FOR SERVICES RENDERED TO ME IN ORDER TO PROCESS CLAIMS ON MY BEHALF. *______________________________

I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO DR. WALTER T. SOROKOLIT FOR SERVICES RENDERED. I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY COPAYS OR PROFESSIONAL SERVICES RENDERED THAT ARE NOT COVERED BY MY INSURANCE. *______________________________

I AUTHORIZE DR. WALTER T. SOROKOLIT OR ANY MEMBER OF HIS OFFICE PERSONNEL TO REQUEST AND OBTAIN COPIES OF ANY AND ALL MEDICAL INFORMATION AND REPORTS RELATED TO MY CARE.

*______________________________

I AUTHORIZE DR. WALTER T. SOROKOLIT TO TAKE ANY NECESSARY CLINICAL PHOTOGRAPHS, WITH THE UNDERSTANDING THAT SUCH PHOTOGRAPHS ARE FOR CONFIDENTIAL, CLINICAL RECORD PURPOSES, AND THAT ALL PHOTOGRAPHS REMAIN THE PROPERTY OF THE DOCTOR. *______________________________

OCCASIONALLY SUCH PHOTOGRAPHS ARE USED FOR TEACHING PURPOSES AND FOR ETHICAL SURGICAL PUBLICATIONS FOR THE ADVANCEMENT OF SURGICAL KNOWLEDGE. I WILL or WILL NOT (CIRCLE ONE) PERMIT THE USE OF THESE PHOTOGRAPHS FOR SUCH ETHICAL PROFESSIONAL PURPOSES.

*______________________________

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WITNESS