Med CareEast, P.A.

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PATIENT AUTHORIZATION

You Reserve the Rights to Refuse To Sign This Acknowledgement

I hereby authorize the release of any information to my insurance carriers that was acquired during my course of examination and treatment. I hereby authorize the payment of medical benefits directly to the physicians and I understand that I am responsible for any amount not covered by my insurance.

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Please Print Name Here

_____

Signature

_____

Date