Chicagoland Oculoplastics Consultants

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ASSIGNMENT OF MEDICAL/SURGICAL BENEFIT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____ hereby irrevocably assign and transfer any payment of any and all medical benefits to which I may be entitled for services provided by Chicagoland Oculoplastics Consultants and/or Kathryn P. Winkler, MD and/or Stephen Winkler, MD pursuant to contract of health insurance, group health insurance, Medicare, Medicaid, or any other type or form of insurance whatsoever, and authorize payment of said benefits directly to the aforementioned physician/supplier. This assignment shall be binding up my heirs, executors and administrators.

I understand that I am financially responsible for any unpaid balance reflecting insurance deductibles, coinsurance and non-covered services.

I authorize the release, to my insurance company, of any medical or other information which may be necessary to process claims for services provided to me by the above-named physician/supplier.

Per my request, I authorize the release of pertinent medical records to the physician who referred me, my primary care physician, and any physician/facility I may be referred to.

All photos taken are the property of Chicagoland Oculoplastics Consultants. They may be used for insurance authorization, educational purposes, and medical publications. Original photos cannot be released. This authorization will certify that I give full consent to have photograph(s) taken, whether still or motion and to have said photograph(s), or portions thereof published. Photograph(s) taken for a specific purpose may be used for multiple purposes, including publications and advertising.

A photocopy of this authorization shall serve in the place and stead of this original.

Patient/Authorized Person's Signature _____ Date _____

Witness _____ Date _____