FISHEL

Authorization for Use of "Signature on File" for Medical Claims

Patient Name Social Security #

I do hereby authorize Jennifer Fishel, OD, PA to mark the section "Enrollee's or Authorized Person's Signature" with the notation of "Signature on File".

This section authorizes:

1. The release of any medical information necessary to produce this claim.
2. The release of any medical information from outside sources which may assist in the diagnosis and treatment.
3. Jennifer Fishel, OD, PA to file insurance claims on my behalf for services rendered.
4. Payment of medical benefits to be paid directly to Jennifer Fishel, OD, PA the provider of services herein described.

This authorization has been explained to my full satisfaction. I understand this document's nature and effect, and it will remain in force until terminated by me in writing.

Patient/Guardian Signature Date