



## AUTHORIZATION FOR AUTOFAX AND DIRECT PAYMENT

**Patient Account #** \_\_\_\_\_

I authorize release of information to my insurance companies, and any holder of Medicare and/or other insurance companies. I request that payment of authorized benefits be made on my behalf. I agree to assign benefits payable to the physician or organization furnishing the services. I request that this authorization also apply to all insurance companies. I understand that I am responsible for my bill, including any deductible or portion of my bill not covered or reimbursed by my insurance companies.

I authorize Sarasota Vascular Specialists to act as my agent to help me assure payment from my insurance companies. As part of my treatment, Sarasota Vascular Specialists may prescribe testing procedures to be performed here. I understand that Drs. Samson, Showalter and Lepore are owners, and I have been advised that according to Florida law I am under no obligation to this facility.

I authorize Sarasota Vascular Specialists to release information from my medical record to my referring physician for the purpose of continuing care.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME