

Patient Name: _____

MEDICAL AUTHORIZATION

I authorize St. Louis Medical Rehab Group, LLC, Dr Ali to release or obtain any medical information related to its treatment of the patient. A photocopy of this authorization shall be construed as effective and as valid as the original.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits, to include all major medical benefits. Private insurance and any other health plan benefits to which I am entitled, to.
St. Louis Medical Rehab Group, LLC.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment shall be construed as effective and as valid of the original. I understand that I am responsible for notifying St. Louis Medical Rehab Group, LLC, of any insurance restrictions including pre-certification for treatment and the need to obtain a referral form. I also understand that I am financially responsible for all charges whether or not they are paid by the insurance. I hereby authorize said assignee to release all information necessary to secure payment.

This release form is valid for one year from the date signed.

Signature of patient or responsible individual

Date

Office Staff - Authorization

Date