Springfield clinic

AUTHORIZATION AND ASSIGNMENT

I, _____, hereby authorize Springfield Clinic ("Springfield Clinic" or the "Clinic") to use and disclose my medical information as set forth in the Clinic's Notice of Privacy Practices (as may be amended from time to time), including but not limited to providing such information as is necessary to obtain payment for services rendered by the Clinic from any insurance company. At the same time, I hereby assign to the Clinic and authorize payment directly to the Clinic of any and all payments or benefits due from or payable by any insurance company or other third-party payor, for health care services provided by the Clinic, its partners, employees, agents or independent contractors.

If applicable, I request that payment of authorized Medicare benefits be made either to me or on my behalf to Springfield Clinic for any services furnished me by Springfield Clinic or any of its partners, employees, agents or independent contractors. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that Springfield Clinic does not accept responsibility for collections of my insurance benefits or negotiating the settlement of a disputed claim.

Signature: _____

MRN:_____ Date: _____

A COPY OF THIS AUTHORIZATION WILL BE PROVIDED UPON REQUEST 8158-01/19

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