Matthew A. Berger, MD, PC

340 Montage Mountain Road ●Moosic, PA 18507
Phone (570) 346-3686 ● Fax (570) 207-0615

INSURANCE AUTHORIZATION

Name ____ **Date** __________________ **Patient Account #** ____________________
(Please Print) (Office Use Only)

PATIENT AUTHORIZATION

I authorize the release of any medical information necessary to process insurance claims for payment of medical benefits to Matthew A. Berger, MD, PC for services rendered by the above stated provider.

RIGHT TO WITHDRAW AUTHORIZATION

I understand the nature of this authorization and I may withdraw this voluntary authorization at any time by giving written notice to this office. I further understand withdrawal of this voluntary authorization will not affect any action taken by my health plan in reliance on this voluntary authorization prior to receiving my written notice of withdrawal.

Patient Signature* ____ **Date** __________________________

Legal Guardian Name** ____

Legal Guardian Signature** ____________________________________ **Date** __________________________

WITNESS SIGNATURE

To be completed if the patient is physically unable to provide a signature but has indicated, verbally or behaviorally, that he/she consents to this release.

We affirm that ____ was physically unable to provide a signature, understands the nature of this consent, and freely gave his/her verbal or behavioral consent. This authorization shall remain in effect for twelve months from this date . This may be revoked by verbal or behavioral communication to the treating physician.

Witness Name ____

Witness Signature ____ **Date** __________________________

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*If patient is **14 or older**, patient must sign all paperwork and add legal guardians to their HIPAA.

If patient is **13 or under, a legal guardian must sign all paperwork.

If you have any questions, please ask our staff.