AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ____________________

I understand and consent that McFee Medical Technologies has the right to exchange and/or release any and all portions of my medical record to my insurance company, whether commercial or Medicare. McFee Medical Technologies may also contact my physician's office for any pertinent medical records and/or personal health information (PHI) including but not limited to: requesting a letter of medical necessity and any relevant medical records for insurance purposes.

I understand that McFee Medical Technologies is a non-participating provider with all insurance companies but that McFee Medical Technologies will submit a claim on my behalf. I also acknowledge that McFee Medical Technologies does not accept government assignment and that I will be paid directly by my insurance company.

All of the above has been explained to me and all questions regarding this release have been answered to my complete satisfaction.

____ ____________________

(Signature of Patient or Guardian) (Date)

THIS AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE IT IS SIGNED

nc ROIMMT Rev 2/5/10