



**Center for
Urological
Services, P.C.**

Adult and Pediatric Urology

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AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF MEDICAL BENEFITS

I hereby authorize Center For Urological Services, P.C. to release any medical information necessary to process insurance claims relating to the medical care rendered by Center For Urological Services, P.C.

I also authorize payment of medical benefits to Center For Urological Services, P.C. for any medical care rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by my insurance.

Printed Patient Name

Signature of patient, or, if minor, parent

Date

Printed Name of Parent or Legal Rep.