NORFOLK CENTER FOR CANCER CARE & HEMATOLOGY

RELEASE OF MEDICAL RECORDS/WAIVER

I HEREBY: Authorize payment directly to the above-named medical practice for medical benefits (if any) otherwise payable to me.

I authorize the release of any information acquired in the course of my examination or treatment, and understand that without verification of insurance and/or a referral I will be held responsible for charges incurred and billed directly.

I also understand that in the event that my deductible for the calendar year has not been met I will be responsible for the balance incurred for this visit. I also understand that if this procedure is not considered medically necessary I will be responsible for the charges incurred today.

I verify that the insurance information given to this office is complete.

_____

Signed (Patient or Parent, Guardian if Minor)

_____

PRINT NAME

DATE:_____