JOSEPH KAVCHOK JR. M.D. P.C.
319 MAIN STREET
EMMAUS, PA 18049

AUTHORIZATION TO RELEASE INFORMATION/ ASSIGNMENT OF BENEFITS

I authorize any holder of medical or other information about me, or parties for whom I am responsible, to release such information to any insurance carrier or other party for the purposes of processing insurance claims.

I hereby authorize payment to JOSEPH KAVCHOK JR MD of the insurance benefits otherwise payable to me. I understand that I am financially responsible for the charges not paid by my insurance. A photocpy of this assignment will be considered as valid as the original.

_____
Signature of Patient or Legal Guardian if a minor