

CONTINUED ON BACK →

I hereby authorize Piedmont Oncology Specialists to release any information acquired in the course of my treatment to insurance carriers, attorneys, or agencies involved in the payment of my account as well as any physicians assisting in my care. I hereby assign payment directly to Piedmont Oncology Specialists for medical services rendered to myself or my dependents. I understand that Piedmont Oncology Specialists will only provide services that my physician believes are in my best interest, and I accept financial responsibility for all charges whether or not paid by insurance. I understand that these authorizations will remain in effect as long as my dependent or I remain a patient.

Patient Signature: _____ Date: _____

Relationship to patient, if other than patient: _____

OFFICE USE ONLY: Reviewed and Added to System By: _____

Revised 08/14/06