

**Letter of Assignment**  
**Evan D. O'Brien, M.D., P.C.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1) I authorize direct payment of medical benefits to Evan D. O'Brien, MD, P.C. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance, including, but not limited to, co-payment and deductible amounts. In addition, if my insurance plan requires a co-payment for services provided, I will pay such a co-payment *at the time services are rendered*.

INITIALS: \_\_\_\_\_

2) I authorize Evan D. O'Brien, MD, P.C. to release any medical or incidental information that may be necessary for medical care or for processing applications for financial benefit.

INITIALS: \_\_\_\_\_

3) I certify that the insurance information that I have provided is correct and complete. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

INITIALS: \_\_\_\_\_

4) I also authorize the release of any and all medical records and films from any and all other facilities or physicians that are needed for my medical care.

INITIALS: \_\_\_\_\_

5) A photocopy of these assignments shall be valid as the original.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient's guardian (if patient under 18): \_\_\_\_\_

Date: \_\_\_\_\_