AUTHORIZATION OF PAYMENT

I hereby authorize Masroor Ahmed, M.D., P.A., Pain & Spine Care to release my medical information acquired in the course of my examination or treatment.

I also hereby authorize payment of insurance benefits under the terms of my policy payable directly to Masroor Ahmed, M.D., P.A., Pain & Spine Care for charges. I am financially responsible for charges not covered by my insurance plan.

Signature of patient ____

Date ____