I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am being treated by Dr Kleinman and I give permission to release office medical records.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read a copy of Dr Kleinmans Notice of Privacy Practice.

In consideration of services rendered to the above named, I authorize payment directly to Dr Kleinman. I understand if the Doctor does not receive payment from the insurance company, that I am responsible for payment of any deductable or unpaid balances not covered by the insurance Co. Payment is expected within a reasonable period of time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or authorized person Date