AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE ORTHOPEDIC ASSOCIATES OF PITTSBURGH, INC., TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION AND TREATMENT TO OTHER HEALTHCARE PROVIDERS INVOLVED IN MY CARE, TO MY INSURANCE COMPANY OR TO PARTIES RESPONSIBLE FOR PROCESSING HEALTH INSURANCE CLAIMS.

______________________________________	______________________
Signature of Patient (If patient is a minor, signature of parent or guardian)	Date

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE PAYMENT OF MEDICAL/SURGICAL BENEFITS TO ORTHOPEDIC ASSOCIATES OF PITTSBURGH, INC. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE BALANCE OF THIS ACCOUNT.

______________________________________	______________________
Signature of Subscriber/Responsible Party	Date