Authorization for Treatment of an Auto Accident Related Injury

Patient Name: _____

Date of Birth: _____ Social Security #: _____

Type of Injury: _____ Date of Accident: _____

Auto Accident Insurance Carrier Information

Name of Insurance Carrier: _____

Policy #: _____ Claim #: _____

Contact Person: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Financial Statement

Please note: If for any reason your auto insurance denies responsibility or discontinues your insurance coverage or benefits, you are fully responsible for any unpaid balance of your injury claim.

Medical Record Release

By signing this document, I hereby authorize my healthcare provider to release information pertaining to this injury including alcohol and drug abuse records protected under the 42 Code of Federal Regulations, Part 2, if any social services records, if any, and psychological services records, if any, including communications made by me to a social worker or psychologist, if any, and all information defined by statue and Michigan Department of Public Health Rules (Public Act 174, 1989) governing Human Immunodeficiency Virus (HIV), HIV test, Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related complex (ARC), if any, to the insurance company listed above.

I will not hold Munson Healthcare liable for any interpretation of the information in my medical record as a result of not having consulted my physician for the correct interpretation.

Please sign below indicating you have completed this form to the best of your knowledge and you have read and understand the terms of this agreement.

Patient Signature: _____ Date: _____

For Office Use Only

Contact: Contact Date:

Notes: Initials: