NON-PARTICIPATING
INSURANCE AUTHORIZATION

(ALLOWS US TO SUBMIT INSURANCE CLAIM ON YOUR BEHALF)

I authorize Dermatology Associates of York, Inc. to release medical or financial records and information related to medical care and treatment provided to me by Dermatology Associates of York, Inc. to the extent reasonably necessary to obtain reimbursement for such services.

- This information could be released to any physician, health care professional, insurance company, health maintenance organization, employer, governmental agency, third party claims administrator, payer of medical care, medical device manufacturer, or any other health care facility involved in my care, including affiliates of Dermatology Associates of York, Inc.

- This release of information may take the form of written records, oral discussions, or direct access to computerized information maintained by Dermatology Associates of York, Inc.

Full Mth day, Year
Pat Whole Name (First Name First)/ Signature # 1
Relationship to Pat Whole Name (First Name First)_____