



Petson Chan
Acupuncture

Authorization to Release Information & Assignment of Benefits

I authorize the release of any information requested to process health insurance claims. I authorize payment to be made directly to Petson Chan Acupuncture and its affiliates. I understand I am responsible for charges not covered by this assignment.

Patient Name: _____

Patient Signature: _____
(Or Patient Representative – Indicate Relationship to Patient)

Date: _____