Evergreen Family Health Partners
Accident Authorization
And Medical Record Release

Patient's Name_____ Date_____

Patient Date of Birth_____ Patient Social Security No._____

Date of Accident_____

Claim # _____

Insurance Carrier:_____

Insurance Claims Address: _____

Insurance Co. Phone #: _____ Policy #: _____

EVERGREEN FAMILY HEALTH WILL SEND A ONE-TIME COMPLIMENTARY CLAIM TO YOUR CARRIER ON YOUR BEHALF. PAYMENTS FOR ALL OUTSTANDING BALANCES ARE THE RESPONSIBILITY OF THE PATIENT FROM THE ORIGINAL DATE OF SERVICE.

I authorize Evergreen Family Health Partners to release medical reports related to my injury to the insurance carrier. I authorize the insurance carrier to send payment directly to Evergreen Family Health.

AUTHORIZED SIGNATURE_____

DATE_____