KAHN, RISKIN & SANTIAGO, MD's, P.A.

4700 Sheridan St, Suite C, Hollywood, FL 33021
Phone- (954) 961-3252 Fax- (954)964-6168

1 SW 129th Ave #401 Pembroke Pines, FL 33027
Phone- (954) 450-8980 Fax-(954) 441-9033

LIFETIME
AUTHORIZATION FOR INSURANCE PAYMENT

I, _____ authorize any holder of medical or other information about me to release to my Insurance Carrier(s) or to the billing agent, of Drs. Kahn, Riskin and Santiago, any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I have been provided with a notice of Privacy Practices of Charles Kahn, MD, FACP, FACR, Wayne Riskin, MD, FACP, FACR, and Dr. Santiago-Casas, MD, FACP,FACR, that HIPPA outlines what will be done with my Protected Health Information.

_____ Print Patient's Name

_____ Patient's Signature

_____ Print Name & Relationship If patient is unable

_____ Signature of Other

Spouse Information (if primary insured)

_____ Name

_____ DOB

_____ Social Security Number