Aida R. Coffey, M.D.
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Office: 512-496-7284, Appointments: 512-306-0740, Fax: 512-263-9975

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process my claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

_____
Signature

_____
Date

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize payment of medical benefits to the undersigned physician or supplier for services described.

_____
Signature

_____
Date