THOMAS E. LIPIN, M.D.
JUPITER EAR, NOSE & THROAT CLINIC

AUTHORIZATION TO RELEASE RECORDS TO INSURANCE CARRIER

I, _____, authorize Dr. Thomas E. Lipin to release to my insurance carrier, any records related to my medical care and/or financial information which may be required for the processing of medical claims.

NOTICE OF PRIVACY PRACTICES

I have reviewed and understand Dr. Thomas E. Lipin's, Notice of Privacy Practices that describes how medical information about myself or the patient I am representative of may be used or disclosed and how I can get access to this information. Please ask the receptionist if you would like a copy of the Privacy Practice.

Name of patient you represent_____

SIGNATURE_____DATE_____