PIP (Personal Injury Protection) AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the release of information to my PIP automobile insurance carrier. I authorize the release of medical, financial or any other personal information, including information about health history, diagnosis, treatment or prognosis with respect to any physical or mental condition including drugs, alcoholism, mental illness and any other non-medical information pertaining to my motor vehicle accident appointment(s). Such information will be used by my PIP automobile insurance carrier to evaluate and process my claim until this coverage has been exhausted or expired. South Tabor Family Physicians LLP will bill motor vehicle appointment(s) after verification of claim is established and until my PIP Automobile coverage has been exhausted or expired.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by my PIP automobile insurance carrier and may not be protected by the federal rule protecting the disclosure of private, medical information. I understand that until this authorization is signed my billing(s) and medical information supporting these services rendered will not be sent to my PIP automobile insurance carrier to process my claim and I am expected to pay for services in full.

This authorization may be revoked in writing to South Tabor Family Physicians LLP. Revocation of this authorization does not extend to action that have already been processed. I understand that this authorization is valid for 365 days from the date of signature.

*****Per Oregon law we will be billing YOUR Auto Insurance Company. If the accident was not your fault, your insurance company will seek reimbursement from the other driver's insurance company.**

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Patient's Name (Printed) Date of Birth

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Name of **YOUR** Auto Insurance Company

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Claims billing address for **YOUR** Auto Insurance Company

____________________________________ ______________________

YOUR PIP Adjustor's Name **YOUR PIP** Adjustor's Phone Number

____________________________________ ______________________

Claim Number Date of Accident

____________________________________ ______________________

Signature of Patient, Parent or Guardian Date

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Relationship to Patient (6/17/15)

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