Aaron
Boone
DO
and
Associates,
PLLC

AUTHORIZATION FOR PAYMENT AND RELEASE OF INFORMATION

I hereby authorize payment to Aaron Boone, DO & Associates, PLLC of any medical or procedural benefits for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company or other related organizations as necessary to process and complete the patient's medical insurance claim, for quality assurance, quality management or utilization management purposes. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS"), Human Immunodeficiency Virus ("HIV"), and/or drug/alcohol use and testing. I acknowledge that any photographs taken by Aaron Boone, DO & Associates, PLLC and/or its employees and contractors will become part of my medical record and may be disclosed in accordance with Aaron Boone, DO & Associates, PLLC's Notice of Privacy Practices. Despite the risk that information transmitted electronically or through facsimile (fax) communication devices may be intercepted or inadvertently transmitted to people not authorized to receive the information, I hereby authorize the transmission of any medical record, or any part thereof, electronically and through facsimile (fax) communication devices.

I authorize Aaron Boone, DO & Associates, its assignees, and third party collection agents to utilize all contact information I have provided to communicate with me. This includes, but is not limited to, home telephone, cellular telephone, and employment telephone. I hereby grant permission and consent to Aaron Boone DO & Associates, PLLC, its assignees, and third party collection agents to place calls to my home telephone, cellular telephone, and employment telephone; leave messages (whether voice or text); and utilize pre-recorded/artificial voice messages and/or automatic dialing devices in connection with any communication to me.

I understand that some procedures/services performed by the physician(s) may not be covered by my insurance plan. If services are not covered, I understand and agree to be financially responsible for payment for such services.