Dr. Ronald S. Mandel
Physician and Surgeon
Board Certified Family Practice

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ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim
I permit a copy of this authorization to be place of the original.

Date:_____Signature:_____

I hereby authorize Dr. Ronald S. Mandel to apply for benefits on my behalf for covered Services rendered by him, or by his order. I request that payment from my insurance Company be made directly to Dr. Ronald S. Mandel (or to the party who accepts Assignment).

I certify that the information I have reported with regard to my insurance coverage is Correct.

I permit a copy of this authorization to be used in place of the original. This authorization
Maybe revoked by either me or my insurance company at any time in writing.

Date:_____Signature:_____