

RAE LOUISE LANTSBERGER, D.P.M.
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SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of pertinent information to all my insurance companies.
- I understand that I am ultimately responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I authorize payment directly to my doctor.
- I permit copy of this authorization to be used in place of the original.
- I authorize the release of my records, x-rays or other information as needed by the insurance companies, consulting physicians, and/or other treating physicians.

PRINT NAME_____

SIGNATURE_____DATE_____