**AUTHORIZATION FOR AUTOFAX AND DIRECT PAYMENT**

I authorize release of information to my insurance companies, referring physicians concerning my condition. I request that payment of authorized benefits be made on my behalf. I agree to assign benefits payable to the physician or organization furnishing the services. I understand that I am responsible for my bill, including any deductible or portion of my bill not covered or reimbursed by my insurance companies.

I authorize Sarasota Vascular Specialists to act as my agent to help me assure payment from my insurance companies. As part of my treatment, Sarasota Vascular Specialists may prescribe testing procedures to be performed here. I understand that Drs. Samson, Lepore, Nair, and Hershberger are owners, and I have been advised that according to Florida law I am under no obligation to have my imaging studies performed at this facility.

I authorize Sarasota Vascular Specialists to release information from my medical record to my primary care physician and my referring physician for the purpose of continuing care.

________________________________ ________________________

PATIENT SIGNATURE PRINT NAME

***What's the number one reason you chose our practice?***

_______Physician referral _______Magazine _______Website _______Lecture

_______Friend or Family _______Health Fair _______Other

**Physician Referral Name**__________________________________________

**Friend or Family Member Name**____________________________________

Did our Physician's reputation influence your decision? _____Y _____N

Do you utilize the internet for healthcare advice? _____Y _____N

Have you visited our website www.veinsandarteries.com? _____Y _____N

Email address:_________________________________________________