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PAYMENT AUTHORIZTION FOR:

(1) PAYMENT OF MEDICAL BENEFITS AND
(2) RELEASE OF MEDICAL INFORMATION

I authorize payment of medical benefits to , Jeanette Busch or Acupuncture Associates, PC for acupuncture services rendered to me. Furthermore, I authorize the release of any medical information necessary to process my insurance claims, to the insuring company or agency.

(PRINT NAME)

SIGNATURE ON FILE

DATE