AUTHORIZATION AND ASSIGNMENT

AUTHORIZATION TO RELEASE INFORMATION

I authorize the doctor and his staff named below to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a photostatic copy of this agreement shall serve as the original.

SIGNATURE WITNESS DATE

NOTICE OF ASSIGNMENT

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctor named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

SIGNATURE WITNESS DATE

ASSIGNMENT AND/OR RELEASE AUTHORIZATION IS GRANTED TO:

DR. JOHN I. KELLY
5461 BELLS FERRY ROAD
ACWORTH, GEORGIA 30102
770-928-8800