Karen Raben MD

7000 SW 62nd Avenue Suite 525 Miami, Florida 33143 305-665-0585

Assignment of Insurance Benefits

The undersigned authorizes the release of all medical records, including HIV information, for claims submitted on behalf of myself and or my dependents. I authorize Dr. Karen Raben MD to submit claims for services rendered without obtaining my signature on each and every claim submitted. A photographic copy of this authorization shall be deemed as valid as the original.

I, _____, hereby authorize _____

(Name of insured) **(Name of Insurance Co.)**

to pay and transfer directly to Karen Raben MD, et. al. all benefits payable for their services. I understand that I am ultimately financially responsible for all the charges incurred. Any insurance benefits paid to Karen Raben MD, et. al. will be credited to my account in accordance with the above assignment. If my current policy prohibits direct payment to the doctor, I direct my insurance company to make the check payable to me at the address above (7000 SW 62nd Ave. Miami, Florida 33143)

Any credits will be applied to your account or you may request a refund.

Authorized Signature _____Date _____