AUTORIZATION TO RELEASE INFORMATION
ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize assignee to release any necessary information to secure payment for my care at this facility.

I hereby assign payment of my benefits, including major medical benefits to which I am entitled, private insurance or any other health plan to:

Dr. Cory M. Campbell, D.C.
3750 Dacoro Lane, Unit 135
Castle Rock, CO 80109
EIN: 20-4492098

A photocopy of this assignment is to be considered as valid as the original. This assignment remains in effect until revoked by me in writing.

I understand that I am responsible for all charges whether paid by insurance. If the account is placed under collections, additional charges as permitted by governing laws will be added to the amount due, including but not limited to: agency fees, attorney fees, and court costs.

_____ Date: _____

Please authorize with signature here