POWELL MEDICAL EQUIPMENT
501-D UWHARRIE COURT
RALEIGH, NORTH CAROLINA 27606

Client Name: _____

CONSENT TO RELEASE INFORMATION

I authorize the release of any medical information or other information necessary to obtain reimbursement for services rendered by Powell Medical Equipment.

_____ _____
Patient and/or Responsible Party Date

ASSIGNMENT OF BENEFITS

I authorize the payment of government benefits to myself or to Powell Medical Equipment who accepts assignment. I also authorize payment of medical benefits to Powell Medical Equipment for services rendered.

_____ _____
Patient and/or Responsible Party Date