Direct Assignment of Benefits
&authorization to Release Information

(Benefits are Payable Directly to Provider)

Patient Name _____
Insurance Company _____
Insurance ID# _____

My signature below signifies my authorization to release any information* pertinent to my case to any authorized insurance representative, or to any attorney representing me.** ***My signature below authorizes benefits to be paid directly to:

John Vail, DC
Vail Chiropractic Clinic, PLLC
164 E 4th Street, Ste. 3
Winona, MN 55987
(507) 474-4260
Fax (507) 474-4262

This is a direct Assignment of Rights and Benefits under this policy.

A photocopy of this shall be considered as valid as the original document.

Policyholder's Signature _____

Claimant (PATIENT) Signature _____

Signature of Witness _____

Date Signed _____