



**Insurance Authorization**

I, \_\_\_\_\_ authorize Dr. Jason Dobson to file insurance on my behalf for any eligible services or treatments furnished to me.

I also authorize Dr. Dobson to file any secondary insurance on my behalf.

I further authorize any holder of personal health information about me to release to my health insurance company or companies any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date