

PLEASE READ AND SIGN ALL OF THE FOLLOWING:

I authorize **Gary D. Ott, M.D., Heather L. Sholtis, D.O., Kelly Duckett, D.O.**, to release any medical information to insurance carrier(s) concerning my illness and/or treatment. I authorize and request payment of any medical benefits (including MediGap, Medicare, & Medicaid) directly to **Gary D. Ott M.D.** I agree that this authorization will cover all medical services until such authorization is revoked by me in writing. I agree that a photocopy of this form may be used in place of the original. I understand that I am responsible for any amount not covered by my insurance.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

As required by the new federal HIPPA regulations, I am aware or have been provided access to the Privacy Notice for **Gary D. Ott, M.D., Heather L. Sholtis, D.O., Kelly Duckett, D.O.**, as posted in the office.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**COPY CARDS BELOW**