Sky Ridge Medical Center
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ASSIGNMENT OF BENEFITS

Please read and sign by both X's

I authorize payment of medical benefits to undersigned physicians or suppliers for these services and all future claims. You should also understand you will be responsible for all non-covered services because of lack of authorization or any other reason for denial.

X______________________________________

I authorize the release of any medical information necessary to process this claim and all future claims.

X______________________________________

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Please Print Patient Name Date