

**LIMITED POWER OF ATTORNEY TO MEDICAL PROVIDER**

**LIMITED POWER OF ATTORNEY TO ENDORSE CHECKS AND SIGN ANY DOCUMENT WHICH WILL AUTHORIZE PAYMENT TO MEDICAL PROVIDER FOR SERVICES RENDERED INCLUDING, BUT NOT LIMITED TO, ASSIGNMENT OF BENEFITS, AUTHORIZATION TO PAY MEDICAL PROVIDER, AUTHORIZATION TO RELEASE AND PROVIDE COPY OF INSURANCE POLICY/CONTRACT TO MEDICAL PROVIDER, RELEASE OF MEDICAL RECORDS TO MEDICAL PROVIDER, DEDUCTIBLE INFORMATION AND ACCUMALATION AND RELEASE OF PIP-PAY-OUT SHEET AND PAYMENT LEDGER, ETC.**

Known by all these present, The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint the above-named medical provider and any of its duly authorized agents to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead, to endorse and deposit all checks, drafts or money orders, which are made payable to the undersigned alone or to the undersigned and said medical provider for medical services provided.

Furthermore, the undersigned authorizes the above-mentioned medical provider or any of its agents to sign any document necessary to authorize payment to said medical provider. This may include affidavits of non-ownership of vehicles, insurance forms and any other documents.

The undersigned by these presents does give and grant the above-named medical provider as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary as the undersigned could do personally insofar as authorizing release of medical records, assigning benefits, authorizing payment to medical provider, authorizing release of insurance contract/policy to medical provider, authorizing release of PIP pay-out sheet and payment ledgers and all other related acts.

The undersigned hereby ratifies and confirms all actions taken by said attorney in accordance with this Power of Attorney, which said attorney shall do or cause to be done by virtue of these presents.

**MEDICAL RECORDS AND INSURANCE CONTRACT/PLICY RELEASE**

A photocopy of this document shall be sufficient to authorize any person, corporation, insurance agent, insurance company, physician or entity whatsoever having the undersigned's medical records or insurance policy/contract to release true copies of same to the above-named medical provider. A photocopy of this document shall be considered the same as an original for the purposes herein stated.

**ASSIGNMENT OF BENEFITS**

I hereby irrevocably assign any cause of legal action against my insurance company and any rights and benefits under any policy of insurance, indemnity agreement, or collateral source as defined in Florida Statutes, to the above-named medical provider. I hereby direct my insurance company to mail all checks, drafts and money orders payable to the above-named provider's address listed on the HCFA-1500 form in Box 33, and draw all checks to the above-named medical provider only. **Any deviation from the directives hereinabove shall be considered breach of contract.**

IN WITNESS WHEREOF the undersigned has set their hands this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

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Patient's Signature

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Patient's Name (Printed)