



## Authorization for Release of Insurance

Date: \_\_\_\_\_

I am interested in having surgery with Lafayette General Medical Center. Therefore, I would like you to release any information to determine eligibility, benefits, co-payments or any out-of-pocket expenses.

I also give permission for any insurance company to inform Lafayette General Medical Center of the reasonable and customary reimbursements for my surgical procedure.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

