Raymond M. Chorey
President and Chief Executive Officer

PATIENT FINANCIAL SERVICES AUTHORIZATION TO RELEASE ACCOUNT INFORMATION

First Name of Patient	MI	Last Name

I hereby authorize the following person or company to act as my representative regarding my accounts with SEORMC.

_____

Name of representative (print)

I authorize this person or company to give and receive information regarding my accounts, including releasing billing and medical information, making payments or setting-up payment arrangements, and applying for Financial Assistance or other programs on my behalf.

This authority lasts until I rescind this authority, appoint a new representative, or upon 12 months from the date of signature.

This form is not valid until signed.

Signature of Patient/Guarantor	Date