

Gustavo H. Day, M.D., P.A.

7777 Forest Lane, Suite B416

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Tel: (972) 566-6764

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over to Dr. Gustavo H. Day, all my rights, title and interest to my medical reimbursement benefits under my insurance policy from my Insurance Company.

I understand that I am financially responsible for non-covered services.

Insured or authorized signature

Date

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Gustavo H. Day to disclose all or part of my medical records to any insurance company or association, the Federal or State Government; as such information may be necessary for the completion of all my medical claims.

I understand that the information to be released may include information pertaining to mental or psychiatric related conditions and/or drug or alcohol abuse.

A copy shall be as valid as the original.

Insured or authorized signature

Date