Joseph C. Tauro, M.D.

Assistant Professor of Orthopedic Surgery
New Jersey Medical School
Director, Ocean County Sports Medicine Center

Sports Injuries **Minimally Invasive**
Arthroscopic Surgery **Joint Replacement**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO INSURANCE CARRIER
AND ASSISGNMENT OF BENEFITS TO JOSEPH C. TAURO, M.D.

COMMERCIAL INSURANCE

I hereby authorize release of medical information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO JOSEPH C. TAURO, M.D.

OUT OF NETWORK PATIENTS:
I understand that my benefits will be paid at an out of network rate and payment may come to me. I am responsible to bring in or mail payment and explanation of benefits. We are out of network with most insurances.

I understand that I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

Signature of Patient:_____ Date:_____

9 Hospital Drive **Toms River, New Jersey 08755** **(732) 341-6226**