



LONG TERM AUTHORIZATION

PLEASE PRINT PATIENT'S NAME (First, Middle, Initial, Last).

AUTHORIZATION TO REALEASE INFORMATION AND ASSIGNMENTS OF BENEFITS:

I hereby authorize you to release information acquired in the course of my treatments and examination to **Brian N. Stirling, D.O.** and to appropriate insurance companies so that payment of benefits due to me will be made directly to Brian N. Stirling, D.O.

FINANCIAL RESPONSIBILITY:

I understand that I am financially responsible for all charges that are not paid by my insurance company.

PATIENT RESPONSIBILITY:

I am willing to take responsibility for my own health in such matters as weight, diet, smoking, exercise, alcohol, and drug use and in the following of my doctors' instructions. I understand that abuse in any of these areas may adversely affect my health and treatment.

RELEASE OF INFORMATION:

I do hereby give my permission to discuss results, appointments, and financial information with the following people:

NAME: _____ **RELATIONSHIP:** _____ **PHONE NO** _____
NAME: _____ **RELATIONSHIP:** _____ **PHONE NO** _____
NAME: _____ **RELATIONSHIP:** _____ **PHONE NO** _____

I have read and understand all the above and agree to the terms set forth by **Brian N. Stirling, D.O.**

SIGNATURE

DATE

Brian N. Stirling, D.O.

P.O. Box 431

809 Michigan Avenue

Grayling, Michigan 49738

Telephone 989.348.6610 · fax 989.348.2723