Signature on File Form

Patient's or authorized person's signature:

I, _____ authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to:

Dr. Robert S. Fox, OD
1202 Troy-Schenectady Road
Latham, New York 12110

Signed_____ Date_____

Insured's or authorized person's signature:

I, _____ authorize payment of medical benefits to:

Dr. Robert S. Fox, OD
1202 Troy-Schenectady Road
Latham, New York 12110

Signed_____ Date_____