SIGNATURE ON FILE

I authorize the use of this form on all my insurance submissions and release of information to all my insurance companies and attorneys involved in this case and release them and its staff of any consequences thereof.

I authorize James O. Gordon DC, or any member of his staff to act as my agent to obtain and secure payment from my insurance companies and give permission for appeals processes deemed necessary for denial of claims.

I authorize release of all medical information, history, records, diagnosis, reports or x-rays to Dr. Gordon.

I further authorize payment of bills for services rendered by Dr. Gordon to be paid directly to the provider and permit a copy/facsimile of this authorization to be used in place of the original.

Additionally, for treatment provided including, but not limited, the agreement by the provider to temporarily forbear any collection action or collection proceedings against the patient, the patient assigns all the rights to collect benefits directly from my insurance company for services and treatment that I have received and all rights to proceed against my insurance company in any action including legal suit if for any reason my insurance company fails to make payments of benefits to which is due. This assignment also includes and rights to recover attorney's fees and cost for such action brought by the provider as my assignee from my insurance company.

NAME: ______________________________

SIGNATURE: ______________________________

DATE: ______________________________