Island Endoscopy Center, LLC
1175 MONTAUK HIGHWAY SUITE 1
WEST ISLIP, NY 11795
PHONE# (631) 376-0001

Patient Authorization Form for an Insurance Appeal

Date: _____

Patient/Member Name: _____

Patient #: _____ **DOB:** _____

I hereby authorize Island Endoscopy Center, LLC to appeal my claim with _____ on my behalf, as my Designated Representative. As part of the appeal, I hereby authorize my carrier to communicate with Island Endoscopy Center, LLC in all aspects of the appeal. I understand that these communications may contain the following, all medical and financial information about my treatment relating to my examination.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. This authorization is valid for a period of one year.

_____
Signature of Member or Legal Guardian

_____
Signature of Witness

_____ _____
Name of Witness Title