AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to **MICHAEL LUPOVICI, M.D.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

INSURED SIGNATURE **DATE**

INSURED PRINTED NAME