MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me to release true copies of same to DAVID N. AVERY, D.C., P.A. or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be binding as an original signature page.

Release of information: I hereby authorize this medical provider to furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records, to obtain coverage information telephonically from my insurer, to request a written no-redacted PIP payout sheet from the insurer; and to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, x-rays and MRI's received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and the providers prior express written permission.

ASSIGNMENT OF BENEFITS

I, _____ Hereby authorize _____
(name of insured) (name of insurance carrier)

To pay and mail directly to: **DAVID N. AVERY, D.C., P.A.**
5645 Gulf Drive
New Port Richey, FL 34652

The medical benefits otherwise payable to me for those services, but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to DAVID N. AVERY, D.C., P.A. any said benefits under any policy of insurance, indemnity agreement or any other collateral source as defined in Florida Statues for any services and or charges provided by **DAVID N. AVERY, D.C., P.A.** IN WITNESS WHEREOF the undersigned have hereinto set their hands, this ___ day of _____, 2012.

_____ _____
PATIENTS SIGNATURE PATIENT'S NAME (please print)