

**NORHLAKE CHILDREN'S ASSOCIATES  
142 PROFESSIONAL PARK DRIVE  
SUITE 300  
MOORESVILLE, NC 28117  
(704) 663-5240  
FAX (704) 663-5399**

**Margaret M, Siegel, M.D.  
Mary-Margaret James, M.D.**

**Sara DuMond, M.D.  
Christi Bartell, M.D.**

**Authorization To Release Information  
Authorization To Pay**

Name of Patient(s): \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_ DOB \_\_\_\_\_

Policyholder's SS #: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Insurance Company's Mailing Address: \_\_\_\_\_

I hereby authorize the release of medical information including complete medical records, test results and billing information to my insurance company and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review records for quality improvement initiatives, audit compliance, utilization management and complaint resolution.

I authorize the payment directly to Northlake Children's Associates, P.A. for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, coinsurance, deductibles and noncovered services at the time the services at the time the service is rendered. A photocopy of this authorization shall be considered as effective and valid as the original. By signing this form I acknowledge that I have read and understood the Financial Policy of NORHLAKE CHILDREN'S ASSOCIATES, P.A.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chart Number