Dr. Savoy & Siegel
Optometric Physicians
127 Newark Ave.
Jersey City, NJ 07302
(201) 333-2768

SIGNATURE ON FILE

I authorize the use of this form on **ALL** my insurance submissions.

I authorize release of information to all my **INSURANCE COMPANIES**.

I understand that **I AM RESPONSIBLE** for my bill.

I authorize my doctor to act as **MY** agent in helping me obtain payment from my Insurance Companies.

I authorize payment direct to my doctor.

I permit a copy of this authorization to be used in place of the original.

Name:______________________________ Insurance ID#____________
(Please Print) (if applicable)

Signature:______________________________ Date:_________________