Authorization for Release of Medical-Related Information

I authorize Dr. Scott Herron to disclose complete information to my insurance company concerning his medical findings and treatment of the undersigned.

Further, I authorize him to testify without limitation, as to all medical findings and the treatment administered to the undersigned, in any legal action, suit, or proceedings to which I am, or may become, a party; and I waive on behalf of myself and any persons who may have an interest in the matter all provisions of law relating to the disclosure of confidential medical information.

Patient	Witness
	41278 Margarita Road, Ste. 201
Date	Temecula, CA 92591 Place

Signature on File

I authorize any holder of medical or other information about me to release to (the Social Security Administration and Health Care Financing Administration or its intermediaries, carriers, and agents or name of insurance company), any information needed to determine the benefits for this or a related claim.

Also, I permit a copy of this authorization to be used in place of the original, request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature	Date