

****This form is only to be utilized in the event that GE Centricity is down. ****



Imperial Health

Patient Authorization and Benefit Assignment

I hereby authorize Imperial Health to release as necessary, all medical information for the processing of an insurance claim. I authorize to also obtain all medical history. I also authorize payment of medical benefits to Imperial Health.

I Accept.

I Decline.

Print Name of Patient: _____ Patient Date of Birth: _____

Signature: _____ Date: _____

Relationship to Patient: _____