

  
**ONCOLOGY SPECIALISTS  
OF  
CHARLOTTE, PA**

2711 RANDOLPH ROAD, SUITE 100  
CHARLOTTE, NC 28207  
PHONE: 704-342-1900 FAX: 704-377-0353

James F. Boyd, MD  
Justin P. Favaro, MD, PhD  
Lisa M. Kelley, NP, MS, AOCNP

H. Grant Taylor, MD  
Geoffery S. Chapman, MD

**AUTHORIZATION FORM**

**Assignment of Benefits**

I, the undersigned, have insurance and assign directly to the physicians of Oncology Specialists of Charlotte, P.A. all benefits, if any, otherwise payable to me for services rendered.

**Release of Medical Information**

I hereby authorize Oncology Specialists of Charlotte to release all information necessary to secure payment of benefits. I authorize the use of the below signature on all insurance submissions whether manual or electronic. I also authorize Oncology Specialists of Charlotte to release my medical information, as necessary, to other physicians or medical facilities that I am being referred to.

I also request the following individuals to have access to my medical records, information on my condition and any other Protected Health Information, as needed or requested:

Name \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

**Financial Agreement**

I acknowledge that payment is due at time of treatment, unless other arrangements are made. I accept full responsibility for all charges not covered by my insurance company.

**Treatment Authorization**

I hereby authorize such examinations, treatments, medications, surgical procedures and all other medical procedures as may be prescribed by the physician in charge of my care.

**Privacy Practices**

I hereby acknowledge that a copy of all Privacy Practices and Billing Procedures for Oncology Specialists of Charlotte, P.A. has been made available to me.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_