Dr. Meryl Brownstein O.D.
122 East Putnam Ave
Cos Cob, CT 06807

Insurance Authorization
Signature on File

· I authorize the use of this form on all my insurance admissions.

· I authorize the 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 to obtain payment from my insurance company.

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

Name: ____

Signature: ____

Date: ____