I HEREBY AUTHORIZE DAVID A. HECHT, M.D. TO RELEASE TO PHYSICIANS AND/ OR MEDICAL FACILITIES ANY INFORMATION PERTINENT TO HIS DIAGNOSIS AND TREATMENT.

DATE _____ SIGNATURE _____

I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL OF MY MEDICAL RECORDS TO:
DAVID A. HECHT, M.D., 20201 N. SCOTTSDALE HEALTHCARE DR., #250, SCOTTSDALE, AZ 85255

DATE _____ SIGNATURE _____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED ON MY BEHALF REGARDLESS OF INSURANCE COVERAGE. I AGREE TO PAY MY ACCOUNT WITH THIS OFFICE IN ACCORDANCE WITH THE STANDARD RATES AND PAYMENT TERMS OF THIS OFFICE. IF IT IS DEEMED NECESSARY, IN THE SOLE DISCRETION OF THIS OFFICE, TO REFER YOUR ACCOUNT TO A COLLECTION AGENCY AS A RESULT OF NONPAYMENT, I AGREE TO PAY ANY COLLECTION COSTS INCURRED AS A RESULT, INCLUDING ATTORNEY'S FEES.

DATE _____ SIGNATURE _____

< < < MEDICARE PATIENTS ONLY > > >

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO DAVID A. HECHT, M.D. FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN.
I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS INFORMATION NEEDED TO DETERMINE IF THESE BENEFITS ARE PAYABLE TO RELATED SERVICES.
I REQUEST THAT PAYMENTS OF AUTHORIZED MEDIGAP BENEFITS BE MADE ON MY BEHALF TO DAVID A. HECHT, M.D., FOR ANY SERVICES FURNISHED BY THAT PHYSICIAN.

DATE _____ SIGNATURE _____

PRINTED NAME _____