Surgical Procedure Medical Authorization Release Form

(For Pre-Approval Insurance)

Patient Information

Full Name

Date of Birth

Address

Phone Number

Insurance Provider

Policy / Member ID Number

Treating Physician Information

Physician Name

Physician Contact

Physician Address

Procedure Details

Name of Surgical Procedure

Proposed Date

Hospital / Facility

Reason for Procedure

Medical Authorization and Release

I hereby authorize my treating physician and the facility to release all pertinent medical information relevant to my surgical procedure to my insurance provider for the purpose of pre-approval. I understand this authorization is necessary to proceed with my insurance claim.

Patient Signature

Date