

**RICHARD T. DAUPHINÉ, MD  
CENTER FOR THE KNEE AND SHOULDER**

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:**

I hereby authorize payment, directly to the above named physician, of the surgical and / or medical benefits, to include major medical benefits, otherwise payable to me for his services as rendered. A photocopy of this signed authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature of Insured Person

\_\_\_\_\_  
Date

**AUTHORIZATION TO RELEASE INFORMATION:**

I hereby authorize the above named physician to release to my insurance company any medical information acquired in the course of my examination and / or treatment. A photocopy of this signed authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature of Patient ( Or Parent if Patient is a Minor)

\_\_\_\_\_  
Date