FRAMINGHAM PODIATRY ASSOCIATES
61 Lincoln Street, Suite 210
Framingham, MA 01702
(508)872-9288

Signature on File

☐I authorize use of this form on **all** my insurance submissions.
☐I authorize release of information to all my **Insurance Companies**.
☐I authorize payment direct to my doctor.
☐I permit a copy of this authorization to be used in place of the original.
☐I under that **I am responsible** for my bill if insurance does not cover service.

Name: (Please print) _____

Signature: _____ Date: _____