

**INSURANCE AUTHORIZATION**

**Dr. Joseph P. Prasad**

**1961 Morris Avenue, Suite B4  
Union, NJ 07083  
908-686-0302**

**7 School Road East  
Marlboro, NJ 07746  
732-462-5700**

---

**SIGNATURE ON FILE**

---

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance carriers.
- 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 carriers.
- I authorize payment directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_