

**INSURANCE ASSIGNMENT AND RELEASE**

RAHMANI EYE INSTITUTE, P.C.  
19727 ALLEN RD. SUITE 11  
BROWNSTOWN MI 48183

I certify that I, and/or my dependant(s), have insurance coverage with \_\_\_\_\_ and assign directly  
Name of Insurance Company(ies)  
to Dr. Rahmani all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

\_\_\_\_\_  
Please print name of Patient, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient