Pine Plains Recreation Department

Medical Release Form

Insurance Company Name: _____

Effective Date: _____

Address of Insurance Company: _____

Group Number: _____ Policy Number: _____

Policy Holder's Name: _____

Relationship to Participant: _____

I hereby authorize the release of any medical information which might be needed in connection with payments for medical services. I request that payment under my medical insurance program be made directly to the provider on any bills for services by the provider. *I understand that I am responsible for all cost that is not paid by my medical insurance company.* The town of Pine Plains and the Pine Plains Recreation Department are not responsible for any medical costs.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____