Hybrid Organization

Authorization for Treatment

Release of Information (ROI)

Assignment of Benefits (AOB)

Acceptance of Financial Responsibility

- I hereby give permission for care, medical treatment or services by a Tulalip Tribes healthcare provider.
- I authorize the Tulalip Tribes healthcare provider to release any information acquired in the course of my examination or care to my insurance company.
- I request payment to be made directly to the Tulalip Tribes for benefits due to me for their services rendered.
- I recognize and accept responsibility that I may be responsible for any balances remaining after insurance payment.

_____ _____

Patient Name (please print) **Patient Date of Birth**

_____ _____

Signature of Patient/Legal Guardian **Date of Signature**

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Legal Guardian (printed name) if applicable