CEDAR VALLEY
Digestive Health Center

Cedar Valley Medical Specialists, P.C. Digestive Health Patient Authorization

- I authorize you to give me reasonable and proper medical care by today's standards.
- I authorize Cedar Valley Medical Specialists, P.C. to release any medical information necessary to make a claim.
- I authorize payment of medical benefits to Cedar Valley Medical Specialists, P.C.
- I understand that I am responsible for any balance due on my account.
- I authorize a copy of this information to be as valid as the original.

Patient signature: _____ Date: _____

CEDAR VALLEY
Digestive Health Center
CedarValleyGI.com

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