INTERNAL MEDICINE ASSOCIATES OF MIDDLE GEORGIA
CRAIG CALDWELL, M.D. JEREMY T. GOODWIN, MD.
TAMMY BARNETT, APRN, FNP-C

INSURANCE AUTHORIZATION

PATIENT NAME: _____

INSURANCE COMPANY: _____
Please note any change in insurance carriers.

I request that payment of authorized benefits be made either to me or on my behalf for any services furnished me by Internal Medicine Associates of Middle Georgia, Dr. Caldwell, Dr. Goodwin, Tammy Barnett, APRN, FNP-C including physician services. I authorize any holder of medical or other information about me to release to my Insurance carrier, Social Security Administration and Health Care Financing Administration or its agents or Carriers any information needed to determine these benefits or benefits of related services.

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