Dr. Gail Jackson

Authorization To Pay Doctor

I hereby authorize the _____ Insurance Company to pay by check made out and mailed directly to:

Gail N. Jackson, M.D.
2211 Corinth Ave #210
Los Angeles, CA 90064

The medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services Rendered. This payment will not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in a current manner, any balance of said Professional Service charges over and above this Insurance payment. A Photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____20_____
Name Date

_____ _____
Signature Address

_____
City State Zip