

By signing below I hereby give authorization to Dr. D. Craig Allred and Baylor College of Medicine Breast Center Pathology to directly bill me for the services they will be providing.

Patient's signature

Date

Witness's signature

Date

Witness's name (print)

Please print legibly or type:

Patient's Name: _____

Date of Birth: _____

Social Security Number: _____

Patient Billing Address: _____

