

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize CHESTNUT HILL CARDIOLOGY, LTD. to release to the insurance companies indicated below information concerning my illness and treatments. I also authorize payment of medical benefits to the above named physician or group for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

INSURANCE CARRIER:

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Signature of insured:

Date:

I authorize my medical records to be forwarded to the following physicians participating in my care:

Referring Physician:

Family Physician:

Others:

Authorization is given to Chestnut Hill Cardiology to retrieve lab results and test results from the facilities where these tests were performed.

I authorize confirmation of my appointments at the following telephone #

I also give authorization to leave phone messages on my answering machine or with members of my family who answer the phone.

Signature:

Date: