Dr. Patrick Anderson

Center for Gynecologic Oncology & Women's Health

Patient's Name:_____ DOB: _____

Street Address:_____

City/State:_____ **Zip Code:**_____

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

Authorization for release of information by the Center for Gynecologic Oncology & Women's Health.

I hereby authorize and direct the named practice, having treated me, to release to government agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such services rendered during hospitalization and medical care and to permit representative thereof to examine and make copies of all records relating to such care and treatment.

I hereby assign, transfer and set over to the below named Medical Group sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered to myself or my dependent by such Medical Group. A photo static copy of this signature may be used as a substitute.

I understand that I am responsible for any amount not covered by my insurance and I am responsible for any charges incurred by the doctor for my medical care.

ASSIGNMENT: The Center for Gynecologic Oncology & Women's Health.

_____ _____

PRINT NAME of patient or authorized representative **Relationship to patient (if not patient)**

_____ _____

SIGNATURE of patient or authorized representative **Date**

_____

WITNESS

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Email: gyncenter@optimum.net