

COLUMBUS CIRCLE IMAGING

A division of West Side Radiology Associates, P.C.

1790 Broadway New York, N.Y. 10019 .Tel :(212) 977-4100

Assignment of Benefits/Release of Information Authorizations

Patient Name _____

Please Print Name

I hereby authorize and direct the above named medical facility, having treated me, to release to governmental agencies, insurance carriers, and/or others who are financially liable for my medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

_____ Date _____ Signature of Patient or Authorized Representative

I hereby assign, transfer, and set over to the above named medical facility and all its physicians treating me, sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to my self or my dependent in said facility.

_____ Date _____ Signature of Patient or Authorized Representative

MEDICARE ONLY

Medicare # _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to West Side Radiology Associates, P.C. for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable or related services.

_____ Date _____ Signature of Patient or Authorized Representative