WESTSIDE | CARDIOLOGY

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# SIGNATURE ON FILE / RELEASE OF MEDICAL RECORDS

I authorize the use of this form for all of my insurance submissions.

I authorize the release of any or all of my medical information and medical records to all my insurance providers and/or to Medicare/Medicaid (if applicable).

I authorize the release of any or all of my medical information and medical records, as is deemed necessary by my physician at Westside Cardiology, to any other physician, hospital, or other health care provider in order to facilitate the exchange of information necessary to coordinate my medical care.

I understand that I am responsible for my bill, whether or not the charges are covered by my insurance.

I authorize my doctor to act as my agent in helping me to obtain payment from my insurance company(ies).

I authorize payment to be made directly to my doctor.

I permit a copy of this authorization to be used in place of an original.

| ______________________________ | ______________________________ |
|---|---|
| Name (please print) | Medicare number (if applicable) |

| ______________________________ | ______________________________ |
|---|---|
| Signature | Date |