Release of Information and Assignment of Benefits

I hereby authorize Pediatric Cardiology Diagnostic Center to release or disclose of any medical information necessary to process my medical claim. I understand that I am responsible for the charges not covered by the insurance. I further authorize a fax or photocopy of this form for the release or disclosure of my medical information to the referring doctor. I also authorize access to my prescription history.

Patient Name _____ DOB _____

Parent or Legal Guardian Signature _____ Date _____

******FOR INSURANCES ONLY *******

Name of Main Subscriber _____ **DOB** _____ **Social Security No.** _____ **Relationship to Patient** _____